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SPECIAL ISSUE

History of Medicine in the Global South



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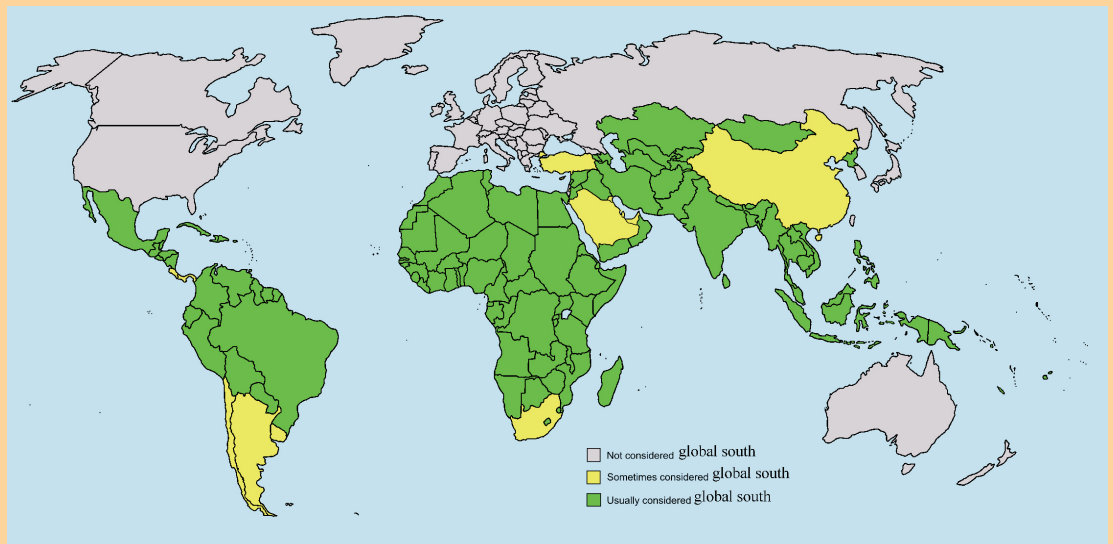


EDITORIAL



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Rohan Deb Roy, Guest Editor

Projected geographies of plantations, diseases and empires, mid-nineteenth century onwards, have borne various uncanny overlaps with one another. Myriad imperial bureaucratic imaginations construed distantly dispersed frontiers, outposts, and landscapes as parts of collectively shared disease ecologies. Thus, ‘mountainous jungles of India’, ‘impenetrable mangrove forests’ in the West Indies, ‘alluvial plains in Algiers’, ‘natural prairies of French Guiana’, ‘arid deserts of Peru and Spanish Guiana’ and Arabia, and the coasts of the Bahamas, Batavia, Coromondal, Ceylon and Sierra Leone, for instance, seemed intimately identical and connected. These were bound by intense regimes of improvement and drug distribution, prescribed for them. ‘Innocent savages’, ‘darker peoples’, ‘innumerable tribes’, ‘stinking negroes’, ‘colonial natives’ and other dwellers of ‘anachronistic spaces’ were shown to inhabit disparate and yet mutually reinforcing composite geographical categories: Hot climates, Indian Ocean region, torrid zone, equatorial belt, the east, tropics etc.

Such politics of region-making continue to inform newer twentieth century categories like the global south or the third world in many ways. Recurrent conversations involving the third world or global south are further provoked by various experiential realities associated with decolonisation, cold war, ethno-nationalist postcolonial regimes, multinational



pharmaceutical empires, corporate charity, proliferation of military markets etc. These conversations, in turn, enable the sustenance of such political regimes and their foundational spatial categories.

Karen Soldatic and Janaka Biyanwila's article in this issue on the 2004 Tsunami in South and Southeast Asia, for instance, elaborates on the production of 'Southern' countries as regions, where spectacular disasters and quotidian disabilities are most 'natural'. It addresses the stereotype that 'freaks of nature' i.e. mudslides, earthquakes, famines etc., 'live (exclusively) in the south'. Such impressions, this article shows, are predicated upon reinvigorated understandings about tropicality and the equatorial belt. Metropolitan technocratic expertise and imperial benevolence are projected as indispensable for the survival of these 'naturally' subordinated parts of the world. Similarly, Lauren van Vuuren's review of the 2005 film *The Constant Gardener* explores how investments and experiments initiated by multinational pharmaceutical corporations shape remote Northern Kenya and the troubled lives of people living there.

Plethora of diseases and inadequate circulation of drugs, along with poverty, starvation, refugees, a growing population, civil wars, political unrest, corruption, poor communications, and inefficiency are defined as among the various afflictions, which collectively signify the global south. In various managerial literatures, these facets are redefined in medical terms i.e. germs of corruption, plagued by Maoism, diseases of poverty and overpopulation, wounded by civil war etc.

This issue explores the collective denigration of disparate clusters of lands and landscapes in immensely proliferating neo-imperial imaginations. Contributors to this issue are equally sensitive to the marginalisation of diverse groups of people as either vulnerable, susceptible or infectious: Black women, sexual deviants, poor whites, Africans, migrant labourers, sick miners, mine-based commercially independent women, white 'amateur prostitutes', 'half castes', Asian and particularly Chinese immigrants, 'indigenous Peruvians', gay men, victims of fatal industrial pollution etc. These appear variously as recalcitrant groups who have to be either quarantined into seclusion or who have been perennially in the need of protection.

This issue of the e-magazine addresses a range of themes which, taken together, cover a period of over hundred years from late nineteenth to the first decade of the twenty-first century. In terms of temporal linearity, it could have more centrally focussed on the theme of transition: From the colonial to the postcolonial; from the postcolonial to neo-imperial situations. While appreciating the historical specificity in each case, however, this issue has instead chosen to juxtapose various temporal and institutional contexts. In so doing, it traces the curious traffics through which the colonial, the national and the neo-imperial shape one another; at the same time emphasising the general patterns of stereotyping lands, landscapes and people beyond particular political and regional contingencies.

Colonial administrations, as Ann Laura Stoler suggests in her most recent book, were prolific producers of social categories. In his contribution to this issue, Daniel Bendix shows how the reality of 'under-population' in

German East Africa was produced in the early twentieth century out of a colonial assemblage of missionary, medical, bureaucratic, and commercial discourses. Similarly, Terence M. Mashingaidze's article details the discursive constitution of the promiscuous and syphilitic body of the mine labourer in colonial sub-Saharan Africa. He argues that enduring conversations between colonial administrators, biomedical authorities, mine owners, and missionaries over questions of cheap labour recruitment and racial difference stigmatised the African male as a hyper-sexualised diseased subject.

Such racially charged essentialisation of 'aberrant sexual behaviour' returned to haunt the Peruvian nationalist literature about venereal diseases in the late nineteenth and early twentieth centuries, as Paulo Drinot shows in his article. Driven by the desire for a racially pure national space, this literature appeared to project the Chinese immigrants, Blacks and 'indigenous Peruvians' as sexually deviant and decadent. Writing about post revolutionary Cuba, Carrie Hamilton shows how predominant official narratives about AIDS victims are shaped by institutionalised homophobia (coupled with the fear about all things foreign/American). In such a situation, any disregard for state-endorsed celebration of the patriarchal male and hetero-normative relationships, she argues, are labelled as counter-revolutionary and reactionary.

Contributions to this issue emphasise a dialogical impulse in the construction of stereotypes about landscapes and people supposedly inhabiting the global south. Far from hinting at unilateral impositions, van Vuuren, Soldatic and Biyanwila refer to the many ways in which, ethno-national governments, media and charitable organisations in the 'south' work within and reinforce the frames of global capital. In such an interactive world, metropolitan Europe itself is shaped in no insignificant way. Bendix's article, for example, suggests that the processes through which the German colonising elite (doctors, administrators, missionaries etc.) in East Africa posited their whiteness against an African population in turn critically informed discourses about the working classes as well as women in contemporary Germany.

This issue studies the extent to which the 'south' is constituted as a sustainable category through the frequent invocations of the 'medical'. It also traces the myriad deployments of the 'medical' in the political histories associated with the unfurling of global capital. Equally, this issue is also a statement about the histories of medicine—its promises, predicaments, embarrassments and apologies. Ryan Johnson's article, rich in its bibliographic detailing, provides a much required critical overview of the trends and shifts that have marked African historiography of medicine: From earlier hagiographic accounts to Marxism-inspired explorations of dependency theory and political economy, from anthropology of African agency and resistance to more recent shifts towards new imperial histories and studies of 'global interconnections', from histories of dialogical interactions to varied racialised and gendered construction of differences. Hamilton's piece comments on the challenges of oral history and suggests plausible ways of rescuing somewhat refracted impressions of a much desired

‘patient’s perspective’ in the histories of medicine. Projit Bihari Mukharji’s insightful review of two recent conferences highlights some of the most knotty theoretical and methodological questions, which are emerging from within the histories of medicine. Mukharji’s comments inspire greater interrogation of categories long uncritically considered foundational in the standard ‘social histories of medicine’. What is the ‘medical’ in the first place? What constitutes the contours of the ‘social’ and the ‘everyday’? And what marks the ‘post-colonial’? Further, he speculates about the future of constructivism in science studies after the ‘nonhuman turn’ has been initiated by the actor-network theorists. In his review of Warwick Anderson’s most recent book, Anirban Das comments on recent traffics between science studies and the histories of medicine. The novelty and richness in this book, Das argues, lay in its ability to invoke complex networks of human and non-human actors, ethics and politics, gifts and markets, philanthropy and pleasure, while explaining the production of the ‘Fore people’ in metropolitan scientific imagination.

We begin this issue with an inspiring conversation with David Arnold, one of the most prolific and important historians of colonial medicine and modern South Asia. He talks in detail, with usual depth and clarity, about his ideological motivations, and concerns, which keep recurring in his works: Colonial medicine, subaltern studies, resistance and power, everyday, global and spatial history etc. He reflects critically on his earlier works, explaining various shifts as well as mapping the possible course of future work. He talks at length about his unpublished and forthcoming works involving everyday technology, food and monsoon Asia. Finally, he shares with us his desire of beginning work on an ambitious project about the twin themes of poison and poverty in South Asian history, beginning with the Bengal famine in the late eighteenth century and ending with the Bhopal gas tragedy of the early 1980s.

The much awaited High court verdict on the Bhopal gas tragedy was declared in June. In an incisive and provocative comment, Atig Ghosh explains the unfolding of the ‘tragedy’ as well as the appalling verdict it did not deserve. The spectre of nefarious alliance between the nation states and big corporations haunts Ghosh’s piece. Any sustained faith in the lullaby crooned by various caretakers of nation states, constitutional justice and democracy then, he argues, has to result from/in pathetic forms of complacent sleepwalking.

In Conversation with David Arnold

Professor David Arnold has been one of the most prolific and important historians of colonial medicine and modern South Asia. A founding member of the Subaltern Studies Collective, he has taught in the School of Oriental and African Studies, University of London for many years, before joining the University of Warwick as a Professor of Asian and Global History. Professor Arnold is a Fellow of the British Academy and the Royal Asiatic Society.



Rohan Deb Roy

Rohan Deb Roy received his Ph.D. last year from the University College London, and is currently a postdoctoral fellow at the Centre for Studies in Social Sciences, Calcutta. In January 2011, he will begin a three-year postdoctoral fellowship at the Department of History and Philosophy of Science, Cambridge. He works on the links between pharmaceutical capital and medical knowledge formation, and on the figure of the 'nonhuman' in imperial history.

Rohan Deb Roy (R): Many look up to you as an inspiring historian. Which authors and events inspired you the most in becoming the historian you are? Who are your favourite historians?

David Arnold (DA): I think that the inspiration I received from particular historians depended on the different phases in my personal evolution as a historian. The inspiration for much of my initial thinking about history came from the social history of the 1960s and 70s, particularly from the work of E.P. Thompson and Eric Hobsbawm and, indeed, the whole generation of people writing social history at that time. Their work seemed to be left wing, more political than much of what went before it, able to open up new and more popular domains of history in ways that seemed not only interesting in themselves but to fit the mood of the time. It took us away from the conventional histories of state, nation and church. Subsequently, I was interested in the linkages between history and anthropology, particularly through the historical anthropology of Bernard Cohn in the South Asia field but also scholars like Eric Wolf and his work on peasants. I continue to think that the link between history and anthropology is a crucial one for historians of South Asia and it continues to influence the way I approach history. Subsequently, Foucault has been the most important single influence on my work and my thinking about history. Of course, Foucault's work takes many forms and it is the early Foucault that I tend to go back to, particularly *Discipline and Punish* and the *Power/Knowledge* interviews rather than the later Foucault of *The History of Sexuality*.

My interest in history has changed over time and so the influences on it have also changed accordingly. I am not sure that I was ever inspired by any one particular book. It is more often the mood or the collective identity of a whole field of history writing that I responded to. I found the Annales School extremely stimulating not for any one single work, though I certainly found Le Roy Ladurie's *Montaillou* and Marc Bloch's work on feudalism, particularly interesting, but it was the methods and approach of the Annales School in general that appealed to me without my necessarily feeling that any particular book was by itself inspirational.

R: What about Ranajit Guha and the Subaltern Studies collective?

DA: At a critical stage in my evolution as a historian, and around the time that the Subaltern Studies group emerged, Ranajit was working on the *Elementary Aspects of Peasant Insurgency*. What inspired me was more his work on that project rather than the book that appeared subsequently. We discussed parts of it, his ideas about inversion, territoriality and so on, over an extended period of time and I greatly benefitted from that. It was not so much Ranajit's published work, which at that point of time principally consisted of the book on the Permanent Settlement in Bengal, that I found inspirational as being involved in the early discussions of the Subaltern Studies group. *Elementary Aspects* is an important book, although I feel now with hindsight there are many things that it does not do that it might perhaps have done, and many assumptions that it makes about peasants that we might now look at rather more critically. I have in mind in particular the way it tends to see the peasantry and the subaltern classes as a kind of universal category from which one can draw parallels from Germany or France without perhaps fully recognising the historical and social specificity of the Indian situation.

R: Medicine was obviously not the first thing you worked on. Following your works on the Congress in Tamilnad, the colonial police, hunger and famine, what motivated your forays into the medical archive?

DA: I have always felt that one has to move on as a historian. The worst thing that a historian, or any scholar, can do is to write the same book fifteen times over. It is important to try to address new fields. That said, though, I would like to think that there is a certain consistency in the work that I have done. My recurrent concern and continuing focus is obviously with India, particularly during the period of colonial rule. Although I have moved beyond India from time to time, that is the location that I have always come back to as my safety zone. I was not intending to work on the police indefinitely, even though I thought it was an important subject then and is one that continues to inform the work I do now. But in writing about the police and in thinking about famine, it was in some ways a natural step to go on to consider the medical material. In looking at colonial policing, for example, I found that the police were sometimes obliged to ‘police’ health conditions, to enforce quarantines, and so on. What we now think of as governmentality created to my mind a kind of continuum between the police and medicine. In *Colonizing the Body*, I was also interested in the relationship between the state and its ideas of medicine and the popular engagement with disease and epidemics, so it seemed an appropriate lateral shift from thinking about the police and its interactions with the people. I did not anticipate at the time how fertile the medical history field might actually be in relation to India. Nothing much had been written about the medical history of India at the time. Whatever was available was frankly pretty boring— a bit about sanitary policy and not much else. I was, of course, aware of the work of Roy Porter and others were beginning to write about the history of medicine in new and interesting ways. So my interest in the history of medicine in India proved to be quite timely.

I do not believe there can be— or needs to be— a single definition of colonial medicine.... I have tried in my own work to think about colonial medicine principally in relation to two issues. Firstly, I see the involvement of medicine in a colonial situation like that among the non-white population of India as a process. The whole point for me in talking about ‘colonising the body’ was to see it not as some kind of absolute control over the body but as a series of discursive and practical interventions by the colonial power that never achieved all its ambitions. It is a process by which medicine impinges on India from outside. It attempts to colonise but remains an imperfect and incomplete process— some things perhaps succeed, others do not. Some objectives are taken up internally (by Indians) and so on. Secondly, I try to think about ways in which colonialism provides us with a specific site of enquiry, one with characteristics of its own that significantly inform and shape the nature of the medicine practised within it.

R: You are now considered one of the leading historians of colonial medicine. If somebody like Shula Marks or Warwick Anderson asked you ‘What is colonial about colonial medicine?’ or ‘Where is the postcolonial history of medicine?’ how would you respond? And is it possible to delineate features of medical history exclusively relevant for the global south or the third world?

DA: I do not believe there can be— or needs to be— a single definition of colonial medicine. One could, of course, start with a rather minimal definition. It can be simply defined as whatever medicine happens to occur in a given colonial context, whether, for example, in the Spanish New World before 1800 or British India or Australia. To that extent, it is about the political contexts in which medicine happens to be practised. But, this definition is extremely narrow and ultimately unhelpful. I have tried in my own work to think about colonial medicine principally in relation to two issues. Firstly, I see the involvement of medicine in a colonial situation like that among the non-white population of India as a process. The whole point for me in talking about ‘colonising the body’ was to see it not as some kind of absolute control over the body but as a series of discursive and practical interventions by the colonial power that never achieved all its ambitions. It is a process by which medicine impinges on India from

outside. It attempts to colonise but remains an imperfect and incomplete process— some efforts perhaps succeed, others do not. Some objectives are taken up internally (by Indians) and so on. Secondly, I try to think about ways in which colonialism provides us with a specific site of enquiry, one with characteristics of its own that significantly inform and shape the nature of the medicine practised within it. So, although we might generalise about colonialism as a whole and trace common characteristics in colonial medicine in general, we still need to recognise that, as in the case of India, there are certain constitutive elements that come from the actual or perceived nature of its physical environment, its cultural conditions, the local mix of colonial power and colonial subjects. We need to see colonial medicine as something which is always in some respects local, and not just a uniform manifestation of some global (or pan-colonial) phenomenon. But I do think that the notion of colonialism, and indeed of colonial medicine, constantly needs to be revisited in the light of new questions. Warwick Anderson's question about 'where is the postcolonial?' is a pertinent question, but, having worked mainly on the colonial period, it is not a question I feel particularly competent to answer, except to say that the more established the idea of the 'postcolonial' becomes, the more urgently we need to have at least a working definition of what constitutes the 'colonial'.

There are, I think, various ways in which we can continue to use the idea of colonial medicine to enlarge the field of enquiry about colonialism and about health and medicine more generally, and one can perhaps do this by standing outside the parameters of what most obviously constitutes the colonial (administrative structures, official policies, colonial agencies, racial identities and so on). For instance, one could, however speculatively, consider the whole nature of health and disease, in the context of South Asia between the 1770s and the 1980 – that is, well beyond independence and into the post-colonial era— in terms of two separate but intersecting modalities or paradigms of poison and poverty. The understanding of many diseases, for example, revolved around those two ideas or shifted from one to the other over time. So, in certain times malaria and cholera were understood as being caused by some kind of poison invading the body from outside. At other times, these and other epidemics were more closely related to understandings of poverty, in itself seen as a fundamental characteristic of India's environment, its economy and society. Poison takes on a distinctive significance in India not just from the long history of poisons that double as therapeutics but also, for instance, from its connection with snake-venom, which in turn has a particular resonance with the perceived nature of India as a perilous environment in which to live. The idea of poison also captures a colonial belief in the insidious and dangerous nature of indigenous medicine: In British eyes, many practitioners of indigenous medicine were, in effect, purveyors of poison. Poisoning has further associations outside of the immediate sphere of medicine, particularly in its association with crime, as in *thuggee*. There are various ways in which the trope of poison continued to inform the understanding of health and well-being in India throughout the colonial period and beyond, as for instance through discussions of environmental pollution (itself a kind of poison) and the harmful effects of urban and industrial waste. My reason for taking 1984 as an end-date is to include the Bhopal tragedy in which poisoning (by gas leaked from a foreign-owned plant) caused death and injury to a very large number of people. Equally, if we take up the idea of poverty in relation to the famines of late eighteenth and nineteenth centuries we can ask various questions as to the linkages made with mortality and disease. How far were famines, and the mortality they caused, understood in terms of the underlying poverty of the people or due, as it were to non-economic factors, to invading epidemics and their specific 'poisons'? Is famine seen to be caused or encouraged by a kind of poverty that is not just economic but is seen to arise from the nature of the Indian environment or from certain kinds of 'impoverishing' social and cultural practices? What I am trying to suggest, then, is that by looking at these kinds of

tropes (and one could choose others), over the whole of that long period of 200 years or so, one can not only see long term trends and shifts in the understanding of health and disease. Further it is possible to come back to the way in which the colonial informs, influences and gives a particular meaning and context to developments in India. I certainly still think there is a great deal that can be done with the idea of colonial medicine, and clearly I do not accept the view of some sceptics who think that there is nothing distinctive at all about colonial medicine. I do recognise the need to continue to unpack the possibilities latent within that term, rather than assuming it as self-evident or that it has already exhausted its utility.

R: There are renewed efforts to initiate greater traffic between medical histories and subaltern studies in South Asia. The category ‘medical’ has undergone scathingly critical interrogation by medical historians themselves, e.g. Roger Cooter. Similarly, the plausibility of convenient and transparent access to subaltern histories has been questioned from within the subaltern studies collective itself. How would you react to proposals for such a marriage at this point?

The attempt to engage the history of medicine more closely with subaltern studies is a valuable and significant move. It forms a kind of continuing trajectory of the original Subaltern Studies project. Even though the Subaltern Studies collective has dissolved and disintegrated, nonetheless the idea of studying the subaltern has remained a very powerful one.... The work I am presently doing on ‘everyday technology’ partly attempts a subaltern approach to the history of modern technology. Looking at subaltern medicine and healing is another way of continuing to do subaltern studies and extending and enriching it in various kinds of ways. It is important, too, because it demonstrates the extraordinary range and variety of what we mean by ‘medicine’. The very idea of medicine can, of course, be critiqued, but it is a convenient umbrella term for thinking about the body, about bodily practices, about ideas of health as well as disease, and about the nature and exercise of authority in society. I would not want to abandon the overarching utility of the term. So if it is a question of whether there should be a stronger connection between subaltern studies and discussions of medicine and health, then absolutely yes. It is not something I am particularly pursuing in my own work at the moment, but I have every sympathy with it.

DA: The attempt to engage the history of medicine more closely with subaltern studies is a valuable and significant move. It forms a kind of continuing trajectory of the original Subaltern Studies project. Even though the Subaltern Studies collective has dissolved and disintegrated, nonetheless the idea of studying the subaltern has remained a very powerful one. In many senses, it remains an unfulfilled project. I think it is perfectly legitimate and desirable for people to take up that project and seek to develop it in new and different directions. The work I am presently doing on ‘everyday technology’ partly attempts a subaltern studies approach to the history of modern technology. Looking at subaltern medicine and healing is another way of continuing to do subaltern studies and extending and enriching it in various kinds of ways. It is important, too, because it demonstrates the extraordinary range and variety of what we mean by ‘medicine’. The very idea of medicine can, of course, be critiqued, but it is a convenient umbrella term for thinking about the body, about bodily practices, about ideas of health as well as disease, and about the nature and exercise of authority in society. I would not want to abandon the overarching utility of the term. So if it is a question of whether there should be a stronger connection between subaltern studies and discussions of medicine and health, then absolutely yes. It is not something I am particularly pursuing in my own work at the moment, but I have every sympathy with it.

R: Talking of Subaltern Studies, I would like to return to some of your earlier writings in the series. In successive essays, i.e. on the Bombay plague (“Touching the Body”) and colonial penology as well as in the classic *Colonizing the Body*, ‘resistance’ figured as a

central problematic in studying the contours of various disciplinary regimes of colonial power and knowledge. You masterfully showed how ‘resistance’ and persuasion towards hegemony could coexist as mutually enabling processes. Studies in various innovations of colonial power appeared to nuance significantly the image of the perfectly mechanised docile subject body. However, in more recent works i.e. those on environment (*Nature, Culture Imperialism* and *The Problem of Nature*) and in the more obvious work of spatial history (*The Tropics and the Traveling Gaze*) your preoccupation with the theme of ‘resistance’ appears to have been considerably displaced. How would you explain this? Has the subalternist in you shifted focus from spectacular and significant resistances to studying minuscule and quotidian habitations of modernity?

DA: I would have to go back to 1960s and 70s to answer that question. That was a period in which there was a rapid growth of academic interest in protest and resistance of various kinds. Much of Thompson, Hobsbawm and Rudé’s work was really about the nature of resistance, whether about peasant resistance in particular or subaltern resistance more generally. And, of course, Ranajit’s work at that time was centrally about resistance too. It was one way of responding to a widely held notion of hegemony as representing a near-complete domination of society without allowing for the possibility of anything operating in opposition to it or qualification of it. Foucault, too, greatly exaggerates the power of the discursive themes of penology and bodily discipline he is talking about. Resistance always has to be part of the story, whether it is effective or not. It was timely to talk about resistance in the 1970s and at that time it was methodologically and intellectually important to do so, particularly in the Indian case where, in the 1960s and 70s, many people thought of India as a society that was never going to be revolutionary. China was revolutionary, India was not. In this view, India was dominated by caste, landlords and religion— it was not about resistance or even substantially about change. So, in writing about resistance one was reacting to ideas of Indian passivity. But that argument has been made and there is no point in continuing to make the case against assumptions of Indian passivity. However, I would suggest that the question of resistance can be understood as an aspect of a wider issue of agency. Writing about resistance involved tracing some form of agency among the subaltern classes— their world-view, their mentality and how it shaped their actions, as in riots and rebellions. The question of agency has been one that has continued to inform my work. What kind of agency, if any, for instance, does a prisoner have in a colonial jail? Does he or she have the ability to ignore the prison regulations, or even to defy them? In many such cases the answer is ultimately ‘no’. But in the short term it might be ‘yes’. There are ways in which situations of power are transformed, qualified, or indeed reinforced, by the very fact that there is resistance, so to my mind agency and resistance are very much bound up together.

The work I am doing at the moment on everyday technology is in some respects about agency too. To what extent does the arrival of the sewing machines, or bicycles, or rice-mills in India from the nineteenth century entail some form of agency, and for whom? I do not want to go back to a technologically deterministic position where one argues that the introduction of such technologies in itself automatically transformed people’s lives. But I would suggest that the acquisition of a bicycle does create the possibility for individuals to change their lives, albeit in a small way. There are elements of resistance to the introduction of new technologies, but that is not the primary response I find in my research. There was some resistance to the introduction of rice-milling, for instance, as opposed to the traditional means of hand-husking rice and that resistance took a variety of forms (including a Gandhian critique of all mechanised milling). But it is the ways in which the machine was adopted and assimilated without a large

measure of popular resistance that interests me most. Perhaps the point should be less about resistance than denial. If we take the case of bicycles, for instance, the question is not one of general resistance to a new technology as such, but it can be about who has the ability to prevent other people from owning or using a bicycle. Up to the 1960s (and perhaps beyond) bicycles were denied to untouchables and many women, particularly low-caste women. So, the question of agency here transforms itself into one of denial. More generally, perhaps, we need to recognise certain distinctions, which I would want to over-exaggerate, between the nineteenth and the twentieth centuries. The nineteenth was a century in which resistance was widely characteristic. One can think not merely about the more spectacular episodes, like the great revolt of 1857, but also all the other peasant revolts. When we move into the twentieth century, unless you are talking about the nationalist movement, or the things that became subsumed into the nationalist movement, I am not sure whether resistance remains such a central, paradigmatic force. It might be supercilious to say that in the nineteenth century people had riots while in the twentieth century they had bicycles, but there is something distinctive about the way in which society changes over time. The characteristics of the nineteenth and early twentieth centuries that were particularly looked at in the early phase of the Subaltern Studies collective were not necessarily those of India as it began to change and emerge in the 1920s, 1930s and subsequently. So, I hope I have not lost sight of the notion of agency and of subaltern agency in particular. But I see it as having shifted in character as times changed, and my work has accordingly tended to move away from that primary emphasis on resistance to the idea of denial, or utility, or assimilation, as constituting a rather different kind of agency.

R: Is it also related to the ways in which the left radical academy has moved away from the question of resistance to understandings of the everyday and everydayness?

DA: Yes. The notion of the everyday is one that has acquired relevance for all kinds of intellectual and academic reasons, but it is something that I think has not been adequately explored in the Indian context. By talking about the everyday it is possible to engage with subaltern experience in new and interesting ways. And the extent to which bicycles and sewing-machines and rice-mills were disseminated by 1920s and 30s is very important to subaltern lives. Although it is quite difficult to recover the evidence for that, there are fragments, there are stories, bits and pieces in the newspapers, that do enable us to begin to construct a rather different notion of subaltern society by the middle of the twentieth century.

R: Are your ongoing projects on ‘monsoon Asia’ and food likely to constitute parts of a single project on everyday technology? Is your most recent book (*The Tropics and the Traveling Gaze*) and the project about ‘monsoon Asia’ your response to the global turn in history-writing?

DA: My immediate task is to write a book about everyday technology in India for the period from 1880s to 1960s. This is a project that has been funded by the ESRC in the UK. However, the wider project is indeed about monsoon Asia. We had a conference here at Warwick a few weeks ago (around April-May 2010), which looked at everyday technology not just in South Asia but also Southeast Asia and there has been some engagement with East Asia as well. One of my responses to the question of how we address global history has been to look (as a number of historians are now beginning to do) at an extended context, ranging across several parts of Asia, and at technologies and material objects that emanate not just from the colonial power or that are not just the product of the internal forces of capitalism within the colony. In a sense, I

am echoing Sanjay Subrahmanyam in trying to identify (albeit for a much later period than he is concerned with) a connectedness that links South Asia, Southeast Asia and East Asia in the late nineteenth century through to the middle of the twentieth century. For me, that connectedness is partly about the movement of certain commodities and about commonality in terms of climate and physical environment, but it is also, for example, approachable in terms of rice-production, rice-consumption, the parallel growth of rice-mills and the nutritional disease beriberi occurring across the whole arc of monsoon Asia. I am not particularly interested in trying to write a global history that tries to encompass the entire globe. But I do recognise the need to step outside the limits of a purely regional approach and employing the concept of ‘monsoon Asia’ is a convenient way of doing this. I also want to engage with the idea of globalisation and globality through the kinds of commodities I am looking at. So, if we are talking about sewing-machines in India, for example, we are looking at a type of machinery that comes primarily from the United States and that says a lot about the extent to which the US was a significant economic and cultural influence upon India even during the period of British colonial rule. I am interested in the way in which certain kinds of global goods, like sewing-machines, became in effect localised through the specific nature of local use, through their social and cultural appropriation and incorporation, as dowry items for example, or for the making of local types of clothing. The multiple engagement between colonialism, international and indigenous capitalism, local consumerism and changing patterns of work and modes of material existence— this is what I am trying to study in my present work. The book about everyday technologies that comes out of this is going to be specifically about India, but I hope that it will engage with some of the issues that the rise of globalisation and global history have made prominent.

Equally, questions of food and medicine have not disappeared from my consideration. Food is something I have come back to in a number of different contexts and indeed the discussion of rice mills in my present project offers another dimension to the question of food as part of the changing nature of food production, the spread of rice-consumption, the mechanisation of food-processing and so on. To go back to what I was saying earlier, I have begun to consider the possibility of writing a book around the twin problematic of poison and poverty, but I am not quite sure how this would work out at the moment. It would be one way of revisiting and revising some of the work that I have done on food and famine in the past, and on particular diseases like beriberi, but, as I tried to explain just now, it would also be a move outside the obviously colonial context and try to treat the period from the 1770s to the 1980s as a whole.

R: Does it mean that culturally sensitive economic histories will be a more overt feature of your current work than ever before?

DA: (Laughs). I have never been an economic historian. I do not spend a lot of time thinking about economic policies or the purely economic nature of the particular commodities I am looking at. Nonetheless, I do recognise that the kinds of commodities I am discussing do exist in a market-place, that they are bought and sold (as well as stolen), and I do need to engage with questions about the scale of importation, changing prices etc. So to that extent perhaps there will be more economic background to this than to any of my previous work. I am also trying to re-examine the nature of capitalism in twentieth-century India and particularly what I think of as *swadeshi* capitalism. The long-term nature of the *swadeshi* movement has not, to my mind, been fully explored as an imaginative idea as well an economic ambition. In Sumit Sarkar’s work the emphasis is on Indians making things for Indians, but there should be an equal emphasis upon Indians selling things to other Indians and for what they see as purposes

beneficial to India and Indians. In the case of bicycles, for instance, it was not until the 1950s that these were being produced in India on an extensive scale. But well before that, there were plenty of Indians who sold them, used them with enthusiasm and saw them having as a positive social and cultural value for Indians' health, mobility and self-sufficiency, and even as having a political significance as part of India's cherished modernity. In that sense, the notion of *swadeshi* capitalism needs to be expanded to address the ongoing social and cultural context as well as its economic meaning and I see everyday technology as one way of trying to do that.

R: You have shown how 'natural' categories like the environment, the tropics etc. are historically produced. Social constructivism in science studies has been discredited by Bruno Latour for having been guilty of sociological reductionism. One disturbing fallout of such critiques has been a biological turn in history writing. Bestselling books like *Echo objects* and *On Deep Histories and the Brain* have boastfully discovered answers to various historical questions in scientific models. Dipesh Chakrabarty's essay on history writing and climate change urges greater recognition of humans as geological actors and insists on the imperative of writing collective species histories of human beings. The contending parties in the blame game appear to allege one another of scientism and sociological reductionism respectively. Would you prefer to take a side in this debate?

DA: I am not sure I would want to because what I have tried to do in my own work is to write about the things that interest me in ways that appeal to me rather than beginning with a grand conception of how the field should advance. My involvement in environmental history in part grew out of the Subaltern Studies project and contemporary interest in environmental issues. I hope that my approach to environmental history incorporates the materialist proposition that there are real things out there in the environment, like microbes and diseases. But, at the same time, they do not exist in isolation but exist in a kind of social dialectic in which they also function as ideas, predicated on all sorts of cultural practices and assumptions. So I would not accept a stark dichotomy between a materialist reading of, say, the environment, and a culturalist one as if the two were entirely different and contrasting things. They feed on one another, and it is the task of the historian not to be a pseudo-scientist and pretend to have scientific insights, or simply to be, as it were, an obsessive culturalist, but to somehow mediate between the two. Historians are well placed to gather certain kinds of evidence from and about the material world but they also need to address a host of subjectivities drawn from the social and cultural domain. I am disinclined to take up your invitation to take sides because I think that taking sides does not actually advance the field. It is rather by interacting with those two possibilities that the history of environment, medicine and science is able to grow and develop new insights.

But to go back specifically to the environmental question, one of the things that I am interested in is space, the spatiality in which colonialism and the other socio-political forces operate. *The Tropics and Traveling Gaze* tried in part to look at the notion of the tropics as a distinctive space in which diseases, plants, people etc. were seen to operate in certain kinds of ways. It was an attempt to study India at a particular point in time but also to move the historical discussion of India into a wider environmental paradigm. My present work on everyday technology is also about space, but about the different kinds of spaces that modern technologies come to occupy— the domestic space in which a sewing-machine is situated and put to work, or the space of the street in which different kinds of technologies coexist and at times collide— bicycles, cars, trams, buses, ox-carts, etc. I am trying to continue to develop the notion of spatiality but not by talking in terms of the tropics, a grand and overtly environmental idea,

but in terms of certain more immediate and intimate modern spaces. In villages, for instance, a case could be made that the arrival of the rice mill. This ushered in a new kind of rural space that was significantly different from what had gone before. I am not really interested a presumed polarity between the material and the discursive. My interest is in finding situations and tropes that enable us to engage with both of these simultaneously.

R: In relation to your works, we have talked about notions of power, resistance, agency, subalternity, space, everyday etc. How would you situate yourself as a historian?

DA: That is difficult because I have not spent much time in trying to define myself. But I suppose there are two or three basic commitments behind my scholarly work. I certainly see myself as, in part, continuing the wider subaltern studies project. Although I often write about the state, or as in recent article about diabetes in relation to the Indian middle classes, it has always been my ambition to get back to the subaltern domain. I do not think that it is an unproblematic domain, nor an isolated and self-contained one, but I would like to regard it as the enduring centre of gravity for most of the work I do. I believe understanding and exploring subalternity is critically important for India, for the history of India and for the writing of history in general. There is a part of me that would always want to write about the histories of the poor. That is where I really feel my locus is. My understanding of Marx, Gramsci, Thompson and Foucault continually brings me back to the question of the poor. All the things that I have written about—policing, crime, famine, disease, technology— all gravitate in the end around the question of the poor. But, at the same time, I would like to regard myself as a historian of India, and of South Asia, and that is the regional field that has, of course, been the main focus of my work over several decades. I believe that it is much more useful (and practicable) to be a historian of India than pretend to be a global historian, which I think of as an unrealisable ambition. Equally, I would always like to write about India beyond the immediate arena of the village and the town, beyond the single province or constituent state. There is a certain collective dynamism about South Asia as a whole that has been particularly in need of historical enquiry and understanding. I have found a lot of enjoyment in studying South Asia over the years. The kinds of topics I have taken up have been ones that have been of personal interest for me and I hope I have communicated something of that personal involvement to others. History has to be written around commitment; it has to be written around belief, enthusiasm and engagement.

To my mind the question of the subaltern is always ultimately connected to issues of poverty and deprivation, with the lack of structural power. I am nervous about notions of the subaltern that extend extensively into the middle class, or the aristocracy, or that simply represent the whole of India as being in some way colonially subaltern. My understanding has always been that it is really about the subordinate sections of society. The value of using the term 'subaltern', rather than the older class terminology, has been that it allows for a certain fluidity in defining how all the different and various subaltern groups are collectively understood. Opening up the subaltern category not just to tribals, peasants and *dalits* but also, say, to women and various low-ranking urban groups makes a lot of sense.

R: But the poor seems to have lost the exclusive attention it used to enjoy within subaltern studies.

DA: To my mind the question of the subaltern is always ultimately connected to issues of poverty and deprivation, with the lack of structural power. I am nervous about notions of the subaltern that extend extensively into the middle class, or the aristocracy, or that simply represent the whole of India as being in some way colonially subaltern. My understanding has

always been that it is really about the subordinate sections of society. The value of using the term ‘subaltern’, rather than the older class terminology, has been that it allows for a certain fluidity in defining how all the different and various subaltern groups are collectively understood. Opening up the subaltern category not just to tribals, peasants and *dalits* but also, say, to women and various low-ranking urban groups makes a lot of sense. It is, of course, important to recognise that there is no clear line between what we call the subaltern and the elite: Obviously society is far more complicated and entangled than that. However, to go back to technology for a moment, there are ways in which we can see manifestations of subalternity through technological engagement. As I have said, subalternity can be manifested in terms of the denial of access to technology by certain kinds of people, like untouchables and women. And yet, there is also the possibility of an escape from subalternity through the opportunities that new technologies make available to people who find ways of becoming small-scale entrepreneurs, who manage to lift themselves out of the peasant community by becoming petty capitalists and small-time entrepreneurs.

I think there are ways in which we can continue to explore that subaltern idea— not as something that is absolute but as a fluid concept that is extremely useful in the context of India and its history but also more generally around the globe. One of the most important achievements of the Subaltern Studies project was that it opened up a dialogue between the history of India and the histories of other parts of the world. If one goes back to the 1960s and 70s, one of the saddening things about South Asian studies was the way in which it was often extremely esoteric and introspective, overly concerned with what was understood to be the idiosyncratic nature of Indian society— the peculiar and complex nature of landlord-peasant relationships, for example, or the specific nature of caste and community. Subaltern Studies, or perhaps the invocation of the subaltern studies idea quite as much as the work of the group itself, has been extremely influential in opening up a whole new way of thinking about social categories and the interactive domains they inhabit.

R: To digress a little: How critical has teaching and supervising been in shaping your research?

DA: I have been extremely fortunate in the Ph.D. students I have had, particularly during my time at SOAS. I am not sure that I contributed much to their evolution but they certainly contributed a lot to mine. I have particularly enjoyed being able to discuss and share ideas with research students and to see through their work the unfolding prospects and possibilities for historical research in the South Asian context. It is really rewarding to see how well they have done following their Ph.D.s. One or two of my books, particularly the one on Gandhi, came directly out of my undergraduate teaching. Teaching encourages one to be schematic about a subject, to think about the wider problematic it presents, and the need to try to put it across in an engaging and thought-provoking way. I would not like to be in a position of a researcher whose output is solely communicated through written papers and occasional seminars. I have particularly enjoyed being at Warwick, where the undergraduate students are very interested and articulate, and being here has been an important stimulus to me at this stage of my career and in thinking about what further work I might want to do.

R: When you look back, how significant has the contribution of South Asian studies been to the general historiography of medicine in the last twenty years?

DA: The contribution that South Asia has made to the history of medicine over the last twenty

years has been enormous. I am not thinking of my own work but that of a whole generation of scholars who have taken the discussion about medicine in South Asia and made it accessible and relevant to those working in other areas such as Africa and Southeast Asia. I would like to think engagement with the history of medicine has been one of the principal ways in which South Asia's scholars have put themselves on the history of medicine world map. At present the standing of South Asian history as a whole is very high. There was a time in the 1960s and 70s when to study South Asian history was to lock yourself in a closet: We have come out of that closet in a big way. Whether South Asia can continue to command the same degree of intellectual and academic authority in the future I do not know, but certainly for the moment it has a very important presence in thinking about colonialism, modernity, identity, community, and the postcolonial. Perhaps that present position creates problems for the future— as to how South Asian history, and especially South Asian medical history, can continue to be innovative and dynamic. We will see.

R: How can histories of medicine repay that debt to South Asian historiography?

DA: It is impossible for me to predict what might happen in the future, particularly in a field as diverse as the history of medicine where different scholars do very different things. I do not think there is a single history of medicine out there that speaks to South Asian history as a whole. But I think that the problematic of the body, which historians of medicine have helped to explore, can become more fully integrated into the wider historiography of South Asia. Many aspects of the history of health still need to be interrogated, not just in a strictly medical sense but also in terms of understandings of social and physical well-being. As I suggested earlier, there are ways in which we can come back to questions of poverty and ask how the history of medicine can contribute more explicitly to an understanding of what poverty is and means in a South Asian context. If we hit the right problematic, we can open up the history of medicine in ways that continue to demonstrate its vitality and relevance for the South Asian field as a whole. There are perhaps ways in which we can conceptualise South Asia as a whole in a more dynamic fashion than we have often done so far. Too often, studies of the history of medicine are about India (or some part of India) or solely about Nepal or Sri Lanka. We need to say more about the ways in which diseases, people and commodities move around South Asia or beyond South Asia into the monsoon Asian arc (as well as in relation to Europe and the metropole). Part of that endeavour also involves moving away from the nation-state by emphasising the constant movements of epidemics, of medical ideas and personnel, throughout South Asia and into the neighbouring regions.

R: It was a real pleasure talking to you. Thank you.

Select Publications of David Arnold

Books (single-authored)

- The Congress in Tamilnad: Nationalist Politics in South India, 1919-1937*, Curzon Press, London, 1977
- The Age of Discovery, 1400-1600*, Methuen, London, 1983; reprinted 1994; Portuguese and Chinese translations; second, enlarged edition, Routledge, London, 2002
- Police Power and Colonial Rule: Madras, 1859-1947*, Oxford University Press, New Delhi, 1986
- Famine: Social Crisis and Historical Change*, Blackwell, Oxford, 1988
- Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India*, University of California Press, Berkeley; Oxford University Press, New Delhi, 1993
- The Problem of Nature: Environment, Culture and the Expansion of Europe*, Blackwell, Oxford, 1996; Japanese, Spanish and Korean translations
- Science, Technology and Medicine in Colonial India*, New Cambridge History of India III: 5, Cambridge University Press, Cambridge, 2000
- Gandhi*, Longman, Harlow, 2001; Portuguese translation 2002
- The Tropics and the Traveling Gaze: India, Landscape, and Science, 1800-1856* Permanent Black, Delhi, 2005; University of Washington Press, Seattle, 2006

Forthcoming:

- (in German) *A History of South Asia* for S. Fischer Verlag, Frankfurt am Main, 'Neue Fischer Weltgeschichte'.

Books (edited)

- Imperial Medicine and Indigenous Societies*, Manchester University Press, Manchester, 1988; Oxford University Press, New Delhi, 1989
- (with Peter Robb) *Institutions and Ideologies: A SOAS South Asia Reader*, Curzon Press, London, 1993
- (with David Hardiman) *Subaltern Studies VIII: Essays in Honour of Ranajit Guha*, Oxford University Press, New Delhi, 1994
- (with Ramachandra Guha) *Nature, Culture, Imperialism: Essays on the Environmental History of South Asia*, Oxford University Press, New Delhi, 1995
- Warm Climates and Western Medicine: The Emergence of Tropical Medicine, 1500-1900*, Rodopi, Amsterdam, 1996
- (with Christopher Shackle) *SOAS since the Sixties*, SOAS, London, 2003
- (with Stuart Blackburn) *Telling Lives in India: Biography, Autobiography, and Life History*, Permanent Black, New Delhi, ; Indiana University Press, Bloomington, 2004
- Burton Stein, *History of India*, Second edition (with new introduction and concluding chapter), Blackwell, Oxford, 2010



Historiography of Medicine in British Colonial Africa



History of Medicine in the Global South

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Historiography of Medicine in British Colonial Africa

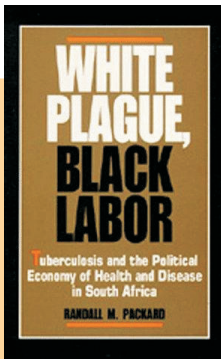
This article provides a critical overview of the debates that have marked African historiography of colonial medicine. It explores the variety of methodological and theoretical approaches that have shaped understandings of African medicine over the past few decades, ranging from earlier hagiographic accounts and explorations of exploitative colonial political economies to the most recent shifts towards new imperial histories and studies of global interconnections.



Ryan Johnson

Ryan Johnson is lecturer in history at the University of Strathclyde and the Centre for the Social History of Health and Healthcare, Glasgow. He recently completed his doctorate at the University of Oxford on aspects of British imperial tropical medicine, c.1890-1914. He teaches British history and European colonial history; and specialises in the history of health, disease and empire.

Since the end of empire in Africa over half a century ago, an ever increasing number of studies have investigated the relationship between colonial rule and western medical practice.¹ Reflecting the diversity of regions falling under British control in Africa, this literature has produced a rich and varied, if not controversial set of arguments. Some of the first histories were unabashed celebrations of advances in so called ‘biomedicine’— primarily the discovery of parasitic diseases²— and the assumed benefits that such discoveries conferred to both European and African populations. Histories also surfaced investigating the building of public health infrastructure and medical institutions. Following these early accounts, scholars informed by dependency theory and the political economy (or ecology) of health and illness, argued that western medical practice was, in fact, not a benign force for good. These studies, typically investigating a specific disease, revealed that rather than alleviating the heavy toll exacted by illness, British colonialism and its disruptive practices often exacerbated it.



White Plague Black Labor

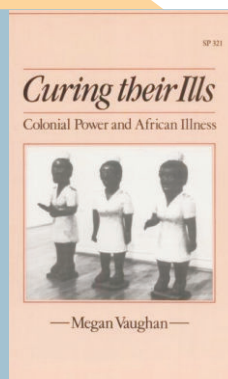
During this time the frame of analysis also moved beyond that of the colonial state, most notably to the work of medical missionaries. And, as with dependency theory and political economy of health approaches, medical anthropologists and sociologists led the way over concerns of African agency, calling into question one-dimensional and passive portrayals of African men and women, and demonstrating the ways in which western medicine was resisted and/or negotiated within a plurality of healthcare practices. Similarly, many began exploring the dialectical relationship between African and western medicines, and the manner in which African health practices informed those of the west.³

All of these approaches to the history of health and healthcare in British colonial Africa remain relevant and active today, becoming increasingly refined as more scholars engage with the period. Discussed further below, this essay suggests that the greatest strides in this respect have been made by reassessing African agency, and challenging monolithic portrayals of the British Empire and western medicine. Perhaps the most important development, like that amongst colleagues studying medicine in the South Asian context, is that historians of health and healthcare in British colonial Africa are no longer mired in local contexts, but are realising the analytical value and need to place their histories within various networks of global interconnections.

Many argued that if colonialism had any benefits, western medicine and public health measures were certainly the most obvious examples. Beginning in the 1970s, several studies also charted the development of western public health infrastructure and medical education in Africa; and while they were not overly triumphalist, they often portrayed western medicine as an exclusively western and powerful ‘civilising’ influence. From Hagiographic Histories to Political Economy and Foucauldian Reflections

Much of the early scholarship on British colonialism and health in Africa was congratulatory,

chronicling the efforts of a few ‘heroic’ scientists and physicians, and their tireless, self-sacrificing and dedicated work.⁴ Many argued that if colonialism had any benefits, western medicine and public health measures were certainly the most obvious examples. Beginning in the 1970s, several studies also charted the development of western public health infrastructure and medical education in Africa; and while they were not overly triumphalist, they often portrayed western medicine as an exclusively western and powerful ‘civilising’ influence.⁵ However, in the few decades after decolonisation, many scholars conducted detailed studies of specific diseases and epidemics in Africa during the period of colonial rule.⁶ While their investigations were generally laden with complex biological and ecological details and demographic data, they came to some inescapable conclusions: Western medicine and its ‘heroic’ practitioners were generally not responding to existing African disease conditions, but to diseases that British colonialism itself had created; and the colonial state was generally ill-equipped to combat such outbreaks. However, a majority of these accounts still clung to the notion that by bringing western medicine to the ‘natives’, colonialism had been a force for good, and encouraged ‘development’ and ‘civilisation’. By the 1980s these studies, while having influenced a number of social scientists and historians, came under attack from scholars advocating a Marxist inspired dependency theory and the political economy of health/political ecology of illness framework.⁷

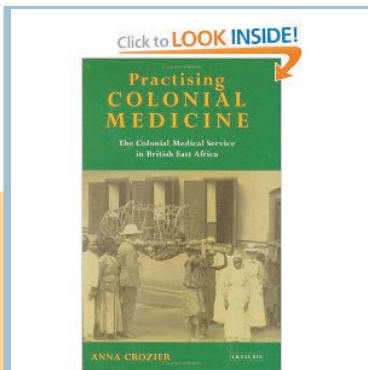


Curing their Ills

Following the lead of John Ford’s study of trypanosomiasis in East Africa, several histories convincingly demonstrated how British colonialism had facilitated the spread of disease that was previously under control or absent in many regions. Marc Dawson, for instance, argued that famines in East Africa, precipitated by colonial rule, had led to massive population movements, which triggered devastating smallpox epidemics.⁸ Perhaps more than any other scholar, Steven Feierman led the way by insisting on the need to analyse the social costs of production in relation to British colonialism and health in Africa.⁹ By engaging in various ‘development’ projects and eradication programmes, the colonial state had transferred the social ‘costs’ of such projects— in this case heavier burdens of disease— onto the most vulnerable populations, mainly women, children and rural inhabitants. Cleansing the study of health and sickness in colonial Africa of its ahistorical and overly ‘scientific’ approaches, it was demonstrated that disease and sickness were not the ‘natural’ conditions of Africa and Africans. Diseases such as schistosomiasis and malaria, as well as famine and illnesses associated with women’s work and migrant labour, were all linked to larger social, political and economic processes engendered by colonial rule. Histories that followed (re)investigated several diseases along similar lines, such as sleeping sickness, plague, tuberculosis and bilharzia.¹⁰

While these approaches remained influential, some anthropologists and historians, informed by the work of Michel Foucault and Edward Said, were investigating the importance

of cultural processes in relation to western medicine and British colonialism in Africa.¹¹ Leading the way in this respect, and arguably one of the more influential studies, was Megan Vaughan's, *Curing Their Ills: Colonial Power and African Illness*.¹² Drawing primarily on the scholarship of Foucault, Vaughan considered the central role of western medicine in relation to colonial power and the construction of racialised and gendered differences between African and Anglo-Saxon minds and bodies. Her scholarship revealed that western medicine's impact was felt at more than just economic and political levels. Western medical knowledge and authority were used to construct differences between British 'colonisers' and African 'colonised'; and to claim European cultural superiority.



Practising Colonial Medicine

Following Vaughan's work, along with a proliferation of studies influenced by postcolonial critiques in general, several histories of health and medicine in British colonial Africa focused on cultural processes and colonial 'mentalities'.¹³ Most of this scholarship took up the call to 'decentre' the binaries of metropole/periphery, coloniser/colonised, and biomedicine/traditional medicine; and provided rich accounts that re-evaluated the relationship between western medicine and European colonialism.¹⁴ In addition, also taking their cue from Vaughan's *Curing Their Ills*,¹⁵ as well as Terrance Ranger's pioneering work on medical missions in Tanzania,¹⁶ several studies traced out the relationship between missionary medicine and colonialism along similar lines.¹⁷

The focus on colonial 'culture' and 'mentalities', whether in relation to the colonial state or British foreign missionaries, has also stimulated a re-evaluation of African agency in relation to western medicine. And, along with the early pioneering work influenced by dependency theory and political economy, historians and social scientists alike are beginning to rethink the local contexts they study in global dimensions.

African Agency and Global Histories

The literature on so called 'traditional' medicine and African 'healers' is, as noted above, quite extensive. Likewise, the work of Africans trained in western medicine has received a good deal of attention.¹⁸ In these accounts, the division between western and 'traditional' medicine is generally quite stable; and 'traditional' medicine is most often viewed as a rigid system, unresponsive to change, compared to a dynamic and evolving 'biomedicine'. Karen Flint, in her book, *Healing Traditions: African Medicine, Cultural Exchange, and Competition in South Africa, 1820-1948*,¹⁹ argues that so-called 'traditional' medicine was not so traditional, but much more interactive and responsive to other medical systems. Africans, in competition with Indians and Europeans, were quick to incorporate therapeutics from 'biomedicine' or Ayurveda if it gave them an edge for patients and income.

In addition to questioning static portrayals of 'traditional' medicine and its practitioners,

scholars have begun to refocus on the agency of medical auxiliaries and subordinates working for either the colonial state or missionary societies.²⁰ One of the most recent and penetrating studies in this respect is Wilima Kalusa's investigation of medical auxiliaries in colonial Zambia.²¹ Kalusa argues that rather than being passive and influential 'imperial' agents of their respective missions, African medical auxiliaries used their training to facilitate their own goals, which were often at odds with those of the mission. Given their lack of local knowledge and ignorance of local language, white European medical missionaries were dependent upon such subordinate personnel. Therefore, African medical auxiliaries were able to incorporate their own beliefs and practices, and further their own ambitions. In this case, Kalusa's study demonstrates that western medicine was never an all powerful hegemonic force, characterised by a set of monolithic practices.

The fact that western medicine was never a stable and universal set of practices, and that it was constantly in dialogue with other medical systems, has prompted historians—willingly or unwillingly—to evaluate its spread and interaction in global perspective. While it has become increasingly common to pay lip service to processes of 'globalisation', approaching the history of health and healthcare in Africa along these lines is opening up valuable new perspectives. Following the lead of historians focusing on South Asia, and through the detailed studies of local African contexts discussed above, cultural processes are becoming better understood in relation to global economic and political networks.

In addition to re-appraising the agency of Africans relative to western medicine, some historians are doing the same to British 'colonisers'. The British, like Africans, have also been boxed into certain roles. Therefore, it is necessary to question accounts of British 'colonisers' that ascribe to them more power and control than they actually had. Anna Crozier, for instance, has argued that British colonial personnel in East Africa were also dealing with attempts to control their behaviour and actions through diagnoses such as 'tropical' neurasthenia.²² Her analysis also points to the fractured and ambiguous state of western medical knowledge, rather than the often monolithic and stable portrayals of 'biomedicine' that appear in many histories of health and healthcare in British colonial Africa.

The fact that western medicine was never a stable and universal set of practices, and that it was constantly in dialogue with other medical systems, has prompted historians—willingly or unwillingly—to evaluate its spread and interaction in global perspective. While it has become increasingly common to pay lip service to processes of 'globalisation', approaching the history of health and healthcare in Africa along these lines is opening up valuable new perspectives. Following the lead of historians focusing on South Asia, and through the detailed studies of local African contexts discussed above, cultural processes are becoming better understood in relation to global economic and political networks. As Helen Tilley has recently argued, African practitioners, by being part of these networks, could also argue for the value of their medical systems by deploying similar claims made by western medical practitioners.²³ Furthermore, if the British Empire and western medicine are understood as fractured and less stable forms of knowledge and power, it becomes easier to appreciate the powerful impacts these claims could have. Not only on the very epistemological foundations of western medicine, or 'biomedicine', but on the course of national and independence movements as well. However, such approaches also reveal the ways in which Britain was still able to take advantage of certain political and material advantages to downplay and counter such claims.

In this respect, much more work is required on the tensions and connections between the many different global networks—scientific, political and economic—that influenced the course of health and healthcare in British colonial Africa. The tireless work and scholarship of

those reviewed above, in this case, will prove invaluable. And, ultimately, in tracing out these tensions and connections, we should always be striving to understand the barriers that still impede millions from living a life free of preventable disease and the immense suffering it creates.

- 1 Throughout, this essay will use the term ‘western medicine’, rather than ‘biomedicine’ or ‘scientific medicine’, to refer to the diverse forms of medicine that were associated with European colonialism, and that were also assumed to have derived from Europe and North America.
- 2 For a history of the new, or ‘Mansonian’ tropical medicine, Michael Worboys’ pioneering scholarship is a required reading. See Michael Worboys, “The Emergence of Tropical Medicine: A Study in the Establishment of a Scientific Specialty”, in G. Lemaine *et al.* (eds.), *Perspectives on the Emergence of Scientific Disciplines*, Mouton, The Hague, 1976, pp. 75-98; M. Worboys, “The Origins and Early History of Parasitology”, in K.S. Warren and J.Z. Bowers (eds.), *Parasitology: A Global Perspective*, Springer-Verlag, New York, 1983; M. Worboys, “Manson, Ross, and Colonial Medical Policy”, in R. MacLeod and M. Lewis (eds.), *Disease, Medicine, and Empire: Perspectives on Western Medicine and the Experience of European Expansion*, Routledge, London, 1988, pp. 21-37; M. Worboys, “Germs, Malaria, and the Invention of Mansonian Tropical Medicine: From ‘Disease in the Tropics’ to ‘Tropical Diseases’”, in D. Arnold (ed.), *Warm Climates and Western Medicine*, Clio Medica, Amsterdam, 1996, pp. 181-207.
- 3 There is an extensive and growing literature focusing on African medicine and health practices. However, this essay is concerned with scholarship investigating the relationship between western medicine and British colonialism in Africa. For a good review of early work on so called ‘traditional’ medicine, see Steve Feierman, “Struggles for Control: The Social Roots of Health and Healing in Modern Africa”, *African Studies Review*, 28, 1985, pp. 73-147.
- 4 For just a few examples see, H. Harold Scott, *A History of Tropical Medicine*, The Williams and Wilkins Co., Baltimore, Md., 1939; Michael Gelfand, *Tropical Victory: An Account of the Influence of Medicine on the History of Southern Rhodesia, 1890-1923*, Juta, Cape Town, 1953; Philip Manson-Bahr, “The March of Tropical Medicine and Hygiene During the Last Fifty Years”, *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 52, 1958, pp. 482-99; and J.J. Mckelvey Jr., *Man Against Tsetse: Struggle for Africa*, Cornell University Press, Ithaca and London, 1973.
- 5 See Ann Beck, *A History of the British Medical Administration of East Africa*, Harvard University Press, Cambridge, 1970; Ralph Schram, *A History of the Nigerian Health Services*, Ibadan University Press, Ibadan, 1971; T.S. Gale, “Official Medical Policy in British West Africa”, Unpublished Ph.D. thesis, SOAS, University of London, 1976; Colin Baker, ‘The Government Medical Service in Malawi: an Administrative History, 1891-1974’, *Medical History*, 20, 1976, pp. 296-311; Michael Gelfand, *A Service to the Sick: A History of the Health Service for Africans in Southern Rhodesia*, Mambo Press, Rhodesia, 1976; Adelola Adelaye (ed.), *Nigerian Pioneers of Modern Medicine: Selected Writings*, Ibadan University Press, Ibadan, 1977; and Ahmed Bayoumi, *The History of Sudan Health Services*, Kenya Literature Bureau, Nairobi, 1979.
- 6 For some of the more influential studies see Raymond E. Dumett, “The Campaign Against Malaria and the Expansion of Scientific Medical and Sanitary Services in British West Africa, 1898-1910”, *African Historical Studies*, 2, 1968, pp. 153-97; John Ford, *The Role of*

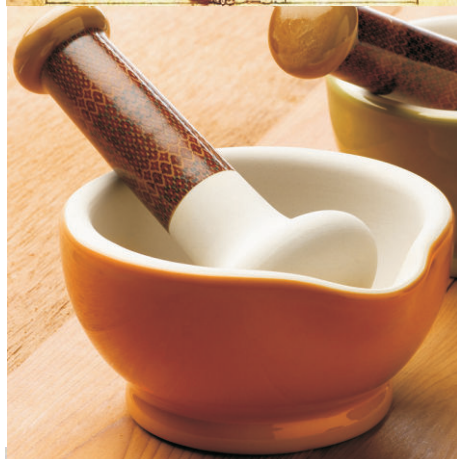
- Trypanosomiasis in African Ecology: A Study of the Tsetse Fly Problem*, Clarendon Press, Oxford, 1971; Helge Kjekshus, *Ecology Control and Economic Development in East African History: The Case of Tanganyika 1850-1950*, University of California Press, Berkeley, 1977; G.W. Hartwig and K. David Patterson (eds.), *Disease in African History: an introductory survey and case studies*, Duke University Press, Durham, 1978; E.E. Sabben-Clare, D.J. Bradley, and K. Kirkwood (eds.), *Health in Tropical Africa During the Colonial Period*, Oxford University Press, Oxford, 1980; and K. David Patterson, *Health in Colonial Ghana: Disease, Medicine, and Socio-Economic Change, 1900-1955*, Crossroads Press, Waltham, Massachusetts, 1981.
- 7 For a good overview of dependency theory and the political economy of health, see Lynn M. Morgan, "Dependency Theory in the Political Economy of Health: An Anthropological Critique", *Medical Anthropology Quarterly*, 1, 1987, pp. 131-154.
 - 8 Marc Dawson, "Disease and Population Decline of the Kikuyu of Kenya, 1890-1925", in Centre of African Studies, University of Edinburgh, *University of Edinburgh Centre of African Studies African Historical Demography*, Vol. II., Centre of African Studies, University of Edinburgh, Edinburgh, 1981, pp. 121-38.
 - 9 Feierman, "Struggles for Control"; and Steven Feierman and John M. Janzen (eds.), *The Social Basis of Health and Healing in Africa*, University of California Press, Berkeley, 1992.
 - 10 See Meredith Thursehn, *The Political Ecology of Disease in Tanzania*, Rutgers University Press, New Brunswick, 1984; Marc H. Dawson, "The 1920s Anti-Yaws Campaigns and Colonial Medical Policy in Kenya", *International Journal of African Historical Studies*, 20, 1987, pp. 417-435; Randall M. Packard, *White Plague, Black Labour: Tuberculosis and the Political Economy of Health and Disease in South Africa*, University of California Press, Berkeley, 1989; John Farley, *Bilharzia: A History of Imperial Tropical Medicine*, Cambridge University Press, Cambridge, 1991; Maryinez Lyons, *The Colonial Disease: A Social History of Sleeping Sickness in Northern Zaire, 1900-1940*, Cambridge University Press, Cambridge, 1992; and Toyin Falola and Dennis Ityavyar (eds.), *The Political Economy of Health in Africa*, Ohio University Press, Athens, 1992.
 - 11 See Michel Foucault, *Discipline and Punish: The Birth of the Prison*, Penguin, New York, 1977; and Edward Said, *Orientalism*, Vintage Books, New York, 1978.
 - 12 Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness*, Cambridge University Press, Cambridge, 1991.
 - 13 While by no means an exhaustive list, good examples of this literature include Heather Bell, *Frontiers of Medicine in the Anglo-Egyptian Sudan, 1899-1940*, Oxford University Press, Oxford, 1999; Jonathan Sadowsky, *Imperial Bedlam: Institutes of Madness in Colonial Southwest Nigeria*, University of California Press, Berkeley, 1999; Osakk A. Olumwullah, *Dis-ease in the Colonial State: Medicine, Society and Social Change Among the AbaNyole of Western Kenya*, Greenwood Press, London, 2002; Sloan Mahone, "The Psychology of Rebellion: Colonial Medical Responses to Dissent in British East Africa", *Journal of African History*, 47, 2006, pp. 241-58; and Anna Crozier, "Sensationalising Africa: British Medical Impressions of Sub-Saharan Africa, 1890-1939", *Journal of Imperial and Commonwealth History*, 35, 2007, pp. 393-415.
 - 14 See Megan Vaughan, "Healing and Curing: Issues in the Social History and Anthropology of Medicine in Africa", *Social History of Medicine*, 7, 1994, pp. 283-95.
 - 15 See in particular, Vaughan, "The Great Dispensary in the Sky: Mission Medicine", in *Curing Their Ills*, pp. 55-76.
 - 16 Terrance Ranger, "Godly Medicine: The Ambiguities of Medical Mission in Southeastern Tanzania, 1900-1945", *Social Science and Medicine*, 15B, 1981, pp. 261-77.

- 17 See John and Jean Comaroff, *Of Revelation and Revolution: The Dialectics of Modernity on a South African Frontier*, Volume 2, The University of Chicago Press, Chicago, 1997, pp. 323-64; Nancy Rose Hunt, *A Colonial Lexicon: Of Birth, Ritual, Medicalization, and Mobility in the Congo*, Duke University Press, Durham, 1999; Charles M. Good Jr., *The Steamer Parish: The Rise and Fall of Missionary Medicine on an African Frontier*, The University of Chicago Press, Chicago, 2004; John Manton, *The Roman Catholic Mission and Leprosy Control in Colonial Ogoja Province, Nigeria, 1936-1960*, Unpublished D.Phil Thesis, University of Oxford, 2005; and Markku Hokkanen, *Medicine and Scottish Missionaries in the Northern Malawi Region, 1875-1930: Quests for Health in a Colonial Society*, Edwin Mellen Press, Lewiston, 2007.
- 18 See Christopher Fyfe, *Africanus Horton: West African Scientist and Patriot*, Oxford University Press, Oxford, 1972; Adelola Adelaye, *African Pioneers of Modern Medicine: Nigerian Doctors of the Nineteenth-Century*, University Press Limited, Ibadan, 1985; Murray Last and G.L. Chavunduka (eds.), *The Professionalization of African Medicine*, Manchester University Press, Manchester, 1986; Karin Shapiro, "Doctors or Medical Aids: The Debate over the Training of Black Medical Personnel for the Black Rural Population in South Africa in the 1920s and 1930s", *Journal of Southern African Studies*, 13, 1987, pp. 234-55; Adell Patton, Jr., *Physicians, Colonial Racism, and Diaspora in West Africa*, University of Florida Press, Gainesville, Florida, 1996; and John Iliffe, *East African Doctors: A History of the Modern Profession*, Cambridge University Press, Cambridge, 1998).
- 19 Karen Flint, *Healing Traditions: African Medicine, Cultural Exchange, and Competition in South Africa, 1820-1948*, Ohio University Press, Ohio, 2008.
- 20 For an excellent pioneering investigation of African medical auxiliaries see Maryinez Lyons, "The Power to Heal: African Medical Auxiliaries in Colonial Belgian Congo and Uganda", in Dagmar Engels and Shula Marks (eds.), *Contesting Colonial Hegemony: State and Society in India and Africa*, I.B. Taurus, London, 1994, pp. 202-223.
- 21 Wilima T. Kalusa, "Language, Medical Auxiliaries, and the Re-interpretation of Missionary Medicine in Colonial Mwinilunga, Zambia, 1922-51", *Journal of Eastern African Studies*, 1, pp. 57-78.
- 22 Anna Crozier, "What Was Tropical about Tropical Neurasthenia? The Utility of the Diagnosis in the Management of British East Africa", *Journal of the History of Medicine and the Allied Science*, 64, 2009, pp. 518-48. Crozier has also investigated European colonial medical personnel in East Africa. See Anna Crozier, *Practicing Colonial Medicine: The Colonial Medical Service in British East Africa*, I.B. Tauris, London, 2007.
- 23 Helen Tilley, "Global Histories, Vernacular Science, and African Genealogies; or, Is the History of Science Ready for the World?", *Isis*, 101, 2010, pp. 110-19.

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The Colonial Fear of 'Underpopulation': Debates on Health and Population in German East Africa



History of Medicine in the Global South

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The Colonial Fear of 'Underpopulation': Debates on Health and Population in German East Africa

Studies on the history of medicine date the beginning of welfarist colonial medicine and health to the 1920s— a time, when Germany no longer had colonies in what is today known as the Global South. However, it seems that the German Empire turned to such policies with regard to the inhabitants of its colonies as early as the start of the twentieth century, as a reaction to the violent colonial wars it fought, which had resulted in a high number of African casualties. As part of this turn in colonial policies and as a reaction to a perceived 'underpopulation', reproductive health and population issues emerged on the agenda of German colonialists in German East Africa. While the motivations were manifold— ranging from economic calculations to missionary 'altruism'— and the disciplinary investment diverse (medical, administrative, economic, missionary), three narratives— culturalist, medical, and modernist— dominated the discussions on 'underpopulation' and served to uphold the German colonisers' political, economic and cultural supremacy. The discussions on reproductive health called for interventions into the individual and social bodies of the colonised and were thus aimed at fundamental transformations of society.

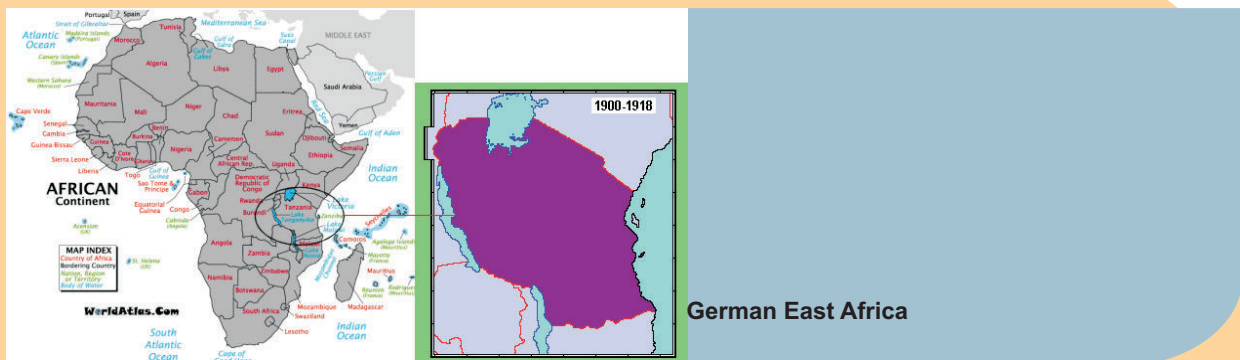


Daniel Bendix

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The Case for a Scrutiny of German Reproductive Health Policy During Colonialism

The German Federal Ministry for Economic Cooperation and Development's latest policy paper on reproductive health and population accords centre stage to the topic of the societal position of women.¹ While this may seem as a new emphasis that emerged in the process leading to the "Cairo Consensus" in 1994² the history of Germany's investment in the lives of women in the Global South dates back to more than a century ago. This fact enticed me to take a closer look at the beginning of Germany's involvement in 'bettering' the lives of people, and especially women, in the Global South. The turn of the nineteenth century was characterised by two phenomena that were relevant for German health and population policy: First of all, a shift took place in Germany's colonial policy in Africa. Colonial administrators and observers cautioned against a population decline, and Africans came to be considered as a resource in need of protection, preservation and enhancement. This is exemplified by a statement by the German State Secretary for Colonial Affairs, Bernhard Dernburg, in 1908, who claimed that the "natives" were "[t]he most important resource in Africa".³ Second, "underpopulation" had started to become an inner-German debate as well.⁴ The nineteenth century had been dominated by discussions on how to stop the 'population explosion' of the working classes. Now, abortions, contraception and venereal diseases became a matter of concern, since they were thought to result in an undesired decrease in birth rates and harm the 'social body'.



Scholars of western colonialism date the prevalence of discourses on 'underpopulation' to the 1920s and relate this to questions of controlling the access to potential workers. My supposition is that the German colonisers came to occupy themselves with questions of population and reproductive health earlier than other nations because of the devastating wars they had fought and in which they had killed hundreds of thousands of people. Not only the decimation of population but the resistance of the colonised as well contributed to a transformation of colonial policy towards a more 'caring' approach.⁵ Instead of trying to verify what the German observers discussed,⁶ I shall rather analyse the discourses that dominated the field and take a look at the intertwining of knowledge production and power relations. I shall examine the political and academic publications that dealt with reproductive health with regards to "German East Africa" at the beginning of the twentieth century. Whether they were 'correct' or not is of secondary interest— they were real and deeply interwoven with colonialist material practices such as assembling statistics, building hospitals, and controlling the sick. The focal point of discussion was the individual and social bodies of the 'others'. This tended to take place with reference to the hegemonic norms regarding sexuality, gender and class in Germany at the time and with regards to the motive of economic exploitation and political control by the colonisers. To understand how the colonisers' discourses constructed notions of difference or whiteness and established and upheld supremacy, I shall analyse the discourses as

interconnected with the issues preoccupying politics and science in Germany at that time, and resort to Roland Barthes' and Frantz Fanon's insights into the establishment of white supremacy through mystifying the world, rendering it a-historical and applying Eurocentric categorisations.⁷ Barthes discerned a collection of psycho-social strategies— what he called myth— with which white people construct themselves as middle class, white and superior. And Frantz Fanon saw the danger of a “rhetoric of supremacism”⁸ in that it fixes the world in images that support the status quo and make change impossible.⁹ I argue that colonial reproductive health discourses on German East Africa constituted an intervention into the individual and social bodies of the colonised and had the effect of establishing and upholding relations of dominance between colonisers and colonised.

Colonial Health and Medicine as “one of the greatest successes of modern history”?

Systematic colonialist health policy started at the turn of the twentieth century, when colonialist administrations founded ‘colonial medicine’ to protect the white colonialists against what were to them unknown diseases and climates; at the same time, western physicians and doctors founded the “politically less charged specialism of ‘tropical medicine and hygiene’”.¹⁰ Germany was no exception to this trend: The institutionalisation of ‘tropical health and medicine’ was undertaken with the publication of journals and the inauguration of institutes and societies. Health policies by European colonial powers followed a similar pattern: At the beginning, Western health care and medicine were brought to the colonies to look after the colonisers and ensure their well-being and survival; after a while, the colonised people forced to work for or employed by the colonisers came to be catered to as well; the third step saw an inclusion of the majority of the indigenous inhabitants as objects of Western medicine, ‘hygiene’ and health care. Michael Worboys claims that since the 1920s, “development was... cast within the framework of the ‘dual mandate’— to develop and protect. Hence, medical welfare services were also spread to towns and rural areas, and— really for the first time— to women and children.”¹¹ This seemed to have been slightly different for the German case: Due to specific historico-political circumstances that I come back to, the ‘welfarist’ move took place more than a decade earlier.

In mainstream examinations of European colonialisms (by Western scholars), health is regularly cited as one of the few areas of colonialist policy with positive outcomes— usually alongside education and infrastructure.¹² This is seen as pertaining to its output in colonialist times as well as to its long-term effects for the post-colonised states: “Whatever political disadvantages colonialism might possess, from the biological standpoint its record is one of the greatest successes of modern history.”¹³ A number of studies claim to take an objective look at colonial health policy, aiming at “a sober account of colonial activities(.)... that openly discusses their effects, acknowledges their achievements, questions their motifs, exposes their misdeeds and defaults, and thus contributes to a less ideological view of the great problems of the African health systems.”¹⁴ While accounts like these are primarily interested in tangible outcomes in the colonised or post-colonised nations and in the gap between words and deeds, I shall concentrate on the role of health and medicine to uphold the supremacy of colonisers and Western knowledge systems.

A different body of work, which inspires my study, understands colonialist medicine and health and its legacy as more fundamentally dominating. These authors take a cultural studies approach to colonialist health policies: They focus on the role of knowledge as power, on health policy as a means of governing populations, and on effects on the identities of the colonisers and colonised.¹⁵ In my analysis of German reproductive health policy in German East Africa, I shall

make use of the insights of observers such as Megan Vaughan who argues that “medicine and its associated disciplines played an important part in constructing ‘the African’ as an object of knowledge”, which served as a means to control the colonised, “and elaborated classification systems and practices which have to be seen as intrinsic to the operation of colonial power.”¹⁶ Colonialist medicine followed a hierarchical categorisation of societies, bodies, thought systems, and practices, and thus reflected the view of the colonisers on the territories and peoples they controlled.¹⁷ Making use of the body as a site of connecting the individual with society, the depiction of non-Europeans as unhygienic was bound up with concrete material practices of segregation and repressive disease control, such as by the German colonisers in the Cameroonian town of Douala in the 1910s.¹⁸ Even though a lot of analogies to gender and class— as hierarchical categorisations present in the colonising nations themselves— can be found in the views on and treatment of Africans by the colonisers, there are some distinctive features to the colonial situations: Because colonialists “found themselves peculiarly foreign and vulnerable”, they were “much more anxious to assign marks of danger to others; lines they drew traced more explicitly than in Europe the boundaries of race”.¹⁹ In this article, I also follow Frantz Fanon in understanding colonial medicine— however benevolent for the individually treated patient— as fundamentally bound up with and serving colonialism as a system of domination and exploitations: “In the colonial situation, going to see the doctor, the administrator, the constable or the mayor are identical moves.”²⁰ This implies that colonialist health policy cannot be examined ‘soberly’ and ‘objectively’, but is intimately connected with broader societal and global processes. In the following, I shall discern the specificities of the German colonial history in German East Africa regarding population and health policy.

1907 was a turning point in the policy of the German Empire towards its African colonies. The change in policy had often been attributed to a moral change of heart on the part of the Germans and a time of rationalisation, reform and progress is said to have ensued. It is, however, more reasonable to understand the changes in German colonialist policy as stimulated by fears engendered by the brutal anti-colonial wars they fought to repress resistance and thus as a reaction to an African initiative rather than a decision controlled by the Germans.

The turn towards colonial development policy

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While one used to colonise by means of destruction, one can now colonise by means of

preservation, which encompasses the missionary as well as the doctor, the railway and the machine, i.e. the progressive theoretical and practical science in all fields.

Important in this regard are not only Dernburg's official statements, but also decrees such as the one by Governor von Rechenberg in 1911 that the dispensaries in German East Africa should serve the health care of the African population. The number of African patients in state institutions increased steadily after 1907: The last official statistics for 1912/13 report 70,327 patients, 93 per cent of which were Africans. We can thus see that German colonial policies in German East Africa that were interested in the welfare of the colonised and could thus be labelled 'colonial development policy' started in the second half of German colonisation. Particularly "the African work force was subsequently treated better"²², but the colonisers also became interested in engaging in less obviously economically motivated areas of health care such as child and maternal health.²³ While the motivations of the involved actors often reflected the so called 'colonial double mandate', i.e. economic interest coupled with moralistic 'altruism', I will now focus on the discourses that characterised the discussions.

In their reasoning, the white authors called for the education and liberation of the black woman, but they did so on the basis of a Christian, sexist, and racist logic. To them, 'improving' the relations between women and men meant introducing the Christian institution of monogamy. It also meant reserving production to men and reproduction to women. The enforcement of Christian monogamy, regarded as modern, was supposed to stop the spread of diseases. The constant mentioning of abortions is an indication that this female means of control over body and reproduction posed a serious threat to patriarchy. Prohibiting abortion and educating black women thus meant intervention in the female body and access to the social body as a whole.

The social position of women

A supposedly problematic population development was regularly connected with the position of women in the 'social body'.²⁴ Marital settings, i.e. 'polygamy', were equalled to 'unstable family situations' and 'disguised prostitution', and blamed for the spread of 'venereal diseases' with their negative impact on population growth.²⁵ In addition to the problematic marital relationships, the commentators also found fault with the extraordinary workload of women²⁶ and their "ignorance in raising children".²⁷ The remedies proposed ranged from the prohibition of abortions' and the improvement of 'midwifery' and 'child care' through 'education' to the spread of the Christian faith.

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imagined body-reality of black people.³⁰ The white colonisers can only grasp the gender relations in the African territories with their own concepts, the concepts they brought from Germany. Interestingly, at the time of feminist struggles for emancipation and equality in Germany, white males in the colonies portrayed the gender relations in Germany as free of sexist oppression.

Bernhard Dernburg



“Infestation by venereal diseases”

Furthermore, the discussion on reproduction and population in the second half of German colonialism focused on diseases, especially venereal diseases and their negative impact on the black population. The white observers did not agree as to the origin of venereal diseases. Some claimed that the colonisers imported them;³¹ others said that they had always existed in the African territories.³² There was, however, consensus on the question of its spread, : ‘Prostitution’ was held responsible for ‘venereal diseases’³³ and ‘bad hygiene’ and ‘superstition’ for other ‘diseases’.³⁴ The spread of diseases was seen as a threat to the economic activities of the Germans because it harmed the ‘human material’. Here, the entanglement of medical with economic logic becomes evident. Or, as the German ‘tropical’ doctor Ludwig Külz put it in 1911, “The colonial economy should make use of the Africans arms, and hygiene should keep them strong and increase their numbers.”³⁵ The colonisers also collated statistical data on diseases. In the medical logic of sick versus healthy, individual people were formed into totalities, into ‘social bodies’. The body served as the primary place for connecting the individual to society. Statistics, in their apparent neutrality and objectivity, are means by which individuals are grouped and linked to phenomena (in this case, ‘disease’) which paves the ground for medical intervention into the social body.

Around 1900, the term epidemic changed its meaning in Germany. The bacteriological explanation for certain diseases implied that every individual was in potential danger of infection and that diseases could no longer be attributed to the ‘lower classes’ and their lifestyle and living conditions only. Similarly, in the case of publications on the colonies, diseases such as syphilis were attributed to the Africans and their peculiar customs and traditions, but ‘whites’ were also seen as prone to infection. The difference was that the diseases were inscribed in the black social body as a whole—Külz spoke about an “infestation by venereal diseases” with regard to the German colonies in Africa—³⁶ whereas white males contracted them as careless individuals that could not be convinced to not make use of prostitutes.³⁷ As a consequence, it was the black prostitutes that needed to be controlled, not the white males; a phenomenon which reflected the dealings with prostitution in Germany until the end of the nineteenth century³⁸. The “double moral standard” in Germany at that time, where “strategies to control (venereal disease) patients mainly aimed at the ‘dangerous’ sexuality of women”³⁹ was enhanced even further by racialised perceptions of the colonisers. Black people were thus portrayed as unclean and sick while whiteness was not stereotyped. That whiteness is not a monolithic, space- and

timeless identity marker, but is inflected by other hierarchisation becomes evident when one takes a look at the situation in Germany at the same time: While the German colonising elite (doctors, administrators, missionaries) posited their whiteness against the African population, the working classes as well as women in Germany were stereotyped similarly to the Africans in the colonies.⁴⁰

To regard diseases and their statistical representation as a myth à la Roland Barthes again helps to reveal their function. By focusing on the present situation in the colonies and the prevalence of diseases, the colonisers disguised the violent history of colonisation with its devastating effects on the social and health situation of the colonised. Diseases call for immediate intervention, for action. With the focus on the present, the presence of the colonisers was not questioned and thus naturalised, an act of charity without which the African people would perish. As in the discussion of the position of women, here again one can find forms of transnational identification. The colonisers focused on the same diseases as those connected with the poor in Germany.⁴¹ Thus the concept disease is transferred from class in the German context to race in the colonial context (and perhaps vice versa). Black people as the racialised ‘other’ were not regarded as equals by the white colonisers, as individuals that can catch diseases, but were seen as a contaminated totality. Whiteness in the colonial context— as the implicit opposite— thus appeared pure and healthy and the intervening white actors constituted themselves as subjects.

‘Proletarianisation’– ‘development’ as problem and solution

A third aspect that was mentioned frequently in the discussions on population and reproductive health in ‘German East Africa was ‘proletarianisation’. German settler colonialists and administrators recruited migrant workers— in addition to enslaved Africans, forced labour and local wage labour— for the plantations and for railway construction. These men sometimes stayed away from home for years on end which meant that social structures changed dramatically. German commentators, and especially doctors and missionaries, problematised this effect of the economic system they had imported.⁴² They lamented the “emergence of a proletariat” which was thought to negatively influence fertility.⁴³ In an economic logic, many commentators warned against the ‘infestation’ of whole ‘tribes’ and the loss of valuable ‘human material’. Their reasoning was as follows: Because the men leave, family bonds deteriorate and polygamy, prostitution, abortion, venereal diseases, child mortality rates increase. They thought that the migrant work system took the “natives out of primitive, natural circumstances into the complicated and refined living conditions of a foreign and overwhelming culture”.⁴⁴

Just like in Germany before the First World War, the “wild, hectic pace of urban life” was thus connected to prostitution, unleashed sexuality and the spread of venereal diseases.⁴⁵ The topic of an endangered ‘human material’ dominated debates in Germany since the end of the nineteenth century, and especially since 1910, when one started to problematise a ‘population decrease’ in Germany as well.⁴⁶ What is important to mention here is that the commentators viewed the population and reproductive health situation in the colonies from a modernistic perspective. Supposedly inferior African societies were juxtaposed to a ‘penetrating culture’ that was prone to harm both ‘quantity’ and ‘quality’ of the ‘social body’. By focusing on the influence of the economic system and by naturalising the demand for labourers, the German colonisers once again de-thematized the outright violence that had cost the lives of hundreds of thousands just a few years earlier in the course of the Maji Maji War. Instead of questioning the legitimacy of colonialism as such, the Colonial Office rather proposed “hygienic, social and similar measures... to increase the number of births and decrease

child mortality”⁴⁷. In addition, analysts recommended the statistical recording of births, deaths, and diseases, the control of prostitution, and the deployment of German doctors and the instruction of local health personnel.⁴⁸ Taking into consideration the difference between ‘development’ as historical process and ‘development’ as intervention sheds light on this constellation⁴⁹: While colonisation was seen as a logical and necessary step for the ‘evolution’ of humankind, ‘progress’ was also always associated with disorder in the shape of proletarianisation, overpopulation, diseases, and the like. ‘Development’ as a conscious intervention was thus considered as the positive inflection of progress: Capitalist progress tamed by order, i.e. intervention by the state and by knowledgeable individuals. The control of and care for the black population demanded their submission. Here one finds evidence of one of the most important strategies of the construction of white supremacy: Paternalisation and infantilisation.⁵⁰ The white surveying and evaluating subject is in need of a subordinate partner– the passive, statistical and therefore static ‘human material’– in order to emerge as an active driving force of history.



Ludwig Külz

Reproductive Health Policy as a Means of Upholding Supremacy

To sum up, the German colonisers ‘discovered’ the reproductive health of the colonised in German East Africa as a field of concern and intervention at the beginning of the twentieth century. The debates about a supposed ‘population decline’ in German East Africa were thus dominated by three intertwined narratives which called for interventions into the individual and social bodies of the ‘others’: A culturalist narrative holding ‘customs and traditions’ of the African population responsible; a medical narrative that focused on the spread of diseases by an *inter alia* alleged promiscuity, but also took a social hygiene perspective to connect it to ‘customs and traditions’; and third, a modernist narrative that portrayed the colonial situation as one which confronted the African inhabitants with a superior cultural system and thus demanded paternalistic care for the African population. While the German colonisers thematised various aspects such as the status of women in society, venereal diseases and ‘proletarianisation’, the economic concern of preserving enough and healthy workers for the exploitation of the colonies structured the whole discussion. The discourses around reproduction and population served to justify the colonisers’ presence in German East Africa by de-thematising their responsibility for the bad health and decimation of the African population. The German administrators, missionaries, settlers, and doctors thus constructed themselves as benevolent, irreplaceable, and superior. This historical analysis of the birth of (people-centred) German development policies in Africa renders me sceptical of an unquestioned benevolence of contemporary development policies aimed at the improvement of the reproductive health situation of children, women, and men in so called developing countries. This leaves me with the question, what the people and institutions involved gain– psychologically, culturally, politically, or economically– from their contemporary involvement in reproductive health and population policies in countries of the Global South?

- 1 BMZ, *Sexual and Reproductive Health and Rights, and Population Dynamics. A BMZ Policy Paper, Special 149*, BMZ, 2008, available on <http://www.bmz.de/en/service/infothek/fach/spezial/spezial149pdf.pdf>, accessed on 26.04.2010.
- 2 Due to extensive lobbying by feminist networks from the Global North and South, the outcome of 1994 International Conference on Population and Development (ICPD) in Cairo shifted the conceptualisation of population policy: Instead of focusing on achieving demographic targets, the individual's needs and rights were made central. Amongst other goals to be achieved by 2015, the programme mentioned universal access to reproductive healthcare and reducing maternal mortality by 75 per cent.
- 3 Bernhard Dernburg, *Zielpunkte des Deutschen Kolonialwesens: Zwei Vorträge*, E.S. Mittler, Berlin, 1907, p. 9.
- 4 Thorsten Halling, Julia Schäfer and Jörg Vögele, "Der Mensch als volkswirtschaftliches Kapital. Theorie und Praxis ökonomischer Be- und Entwertung von Bevölkerungsgruppen", in *Ursprünge, Arten und Folgen des Konstrukts „Bevölkerung“ vor, im und nach dem „Dritten Reich“*, 2009, 399, available on http://dx.doi.org/10.1007/978-3-531-91514-2_11, accessed on 26.04.2010.
- 5 John Iliffe, *Tanganyika under German Rule 1905-1912*, Cambridge University Press, Cambridge, 1969, pp. 7-8.
- 6 See, for instance, Juhani Koponen, *Development for Exploitation. German Colonial Policies in Mainland Tanzania, 1884-1914*, LIT-Verlag, Hamburg, 1994.
- 7 Roland Barthes, *Mythen des Alltags*, Suhrkamp, Frankfurt am Main, 1964; Frantz Fanon, *Schwarze Haut, weiße Masken*, Syndikat, Frankfurt am Main, 1980.
- 8 Chéla Sandoval, "Theorizing white consciousness for a post-empire world: Barthes, Fanon, and the rhetoric of love", in Ruth Frankenberg (ed.) *Displacing Whiteness. Essays in Social and Cultural Criticism*, Duke University Press, Durham and London, 1997, p. 68.
- 9 Fanon, *Schwarze Haut, weiße Masken*, p. 71.
- 10 Michael Worboys, "Colonial Medicine", in Roger Cooter and John Pickstone (eds.), *Medicine in the Twentieth Century*, Harwood Academic Publishers, Amsterdam, 2000, p. 70.
- 11 *Ibid.*, 74.
- 12 See e.g. Barnett Singer and John Langdon, *Cultured Force. Makers and Defenders of the French Colonial Empire*, University of Wisconsin Press, Madison, 2004.
- 13 Gann and Duignan cited in Francis Cox, "Conquest and Disease or Colonialism and Health?," *Gresham College*, September 17, 2007, <http://www.gresham.ac.uk/event.asp?PageId=108&EventId=696>.
- 14 Walter Bruchhausen, *Medizin zwischen den Welten. Geschichte und Gegenwart des medizinischen Pluralismus im südöstlichen Tansania*, Bonn University Press, Bonn, p. 20. See also, Cox, "Conquest and Disease"; Wolfgang, U. Eckart, *Medizin und Kolonialimperialismus: Deutschland 1884-1945*, Paderborn, München, Wien and Zürich, 1997.
- 15 Megan Vaughan, *Curing their Ills. Colonial Power and African Illness*, Stanford University Press, Stanford, 1991; Randall M. Packard, "Post-colonial medicine", in Cooter and Pickstone (eds.), *Medicine in the Twentieth Century*, pp. 97-112; Fanon, *Schwarze Haut, weiße Masken*; Pascal Grosse, *Kolonialismus, Eugenik und bürgerliche Gesellschaft in Deutschland 1850-1918*, Campus Forschung, Frankfurt and New York, 2000; Warwick Anderson, "Postcolonial Histories of Medicine," in Frank Huisman and John Harley Warner

- (eds.), *Locating Medical History. The Stories and Their Meanings*, The John Hopkins University Press, Baltimore and London, 2004, pp. 285-306.
- 16 Vaughan, *Curing their Ills*, p. 8.
- 17 Steve Ferzacca, "Post-colonial development and health," in Carl R. Ember and Melvin Ember (eds.), *Encyclopedia of Medical Anthropology. Health and Illness in the World's Cultures*, Vol 1, Springer, New York, 2004, pp. 184-190.
- 18 Andreas Eckert, "Sauberkeit und 'Zivilisation': Hygiene und Kolonialismus in Afrika," *Sozialwissenschaftliche Informationen*, 26, 1, 1997, pp. 16-19; see also Warwick Anderson, "The Third-World Body," in Cooter and Pickstone (eds.), *Medicine in the Twentieth Century*, pp. 235-45.
- 19 Anderson, "The Third-World Body", p. 236.
- 20 Frantz Fanon, *Studies in a Dying Colonialism*, Earthscan, London, 1989, p. 189.
- 21 Iliffe, *Tanganyika under German Rule*.
- 22 Dirk van Laak, "Der deutsche Kolonialismus und seine Nachwirkungen," *APuZ - Aus Politik und Zeitgeschichte*, 4, 2004, p. 9.
- 23 Bruchhausen, *Medizin zwischen den Welten*, pp. 434-51; Bernita Walter, *Von Gottes Treue getragen. Die Missions-Benediktinerinnen von Tutzing - Band II: Gottes Treue verkünden. Wegbereitung für die Kirche in Ostafrika*, EOS Verlag, Erzabtei St. Ottilien, 1992, pp. 305-13.
- 24 Carl Ittameier, *Die Erhaltung und Vermehrung der Eingeborenen-Bevölkerung*, Friedrichsen, Hamburg, 1923, p. 56.
- 25 Thaddeus Sunseri, *Vilimani. Labor migration and rural change in early colonial Tanzania*, Heinemann, Kapstadt, Portsmouth and Oxford, 2002, p. 181.
- 26 Ittameier, "Die Erhaltung und Vermehrung der Eingeborenen-Bevölkerung", pp. 25-26.
- 27 Otto Peiper, "Der Bevölkerungsrückgang in den tropischen Kolonien Afrikas und der Südsee, - seine Ursachen und seine Bekämpfung," in Abteilung I des Ministeriums (ed.), *Veröffentlichungen aus dem Gebiete der Medizinalverwaltung. Im Auftrage des Ministeriums für Volkswohlfahrt XI/7*, Richard Schoetz, Berlin, 1920, p. 420.
- 28 Barthes, *Mythen des Alltags*, p. 86.
- 29 Gayatri Chakravorty Spivak, "Can the subaltern speak?," *Die Philosophin*, 14, 27, 2003, p. 55.
- 30 Fanon, *Schwarze Haut, weiße Masken*, p. 104.
- 31 Bernhard Nocht, *Tropenhygiene*, G. J. Goschen Berlin and Leipzig, 1923, p. 108.
- 32 Oskar Karstedt, "Betrachtungen zur Sozialpolitik in Ostafrika", in *Koloniale Rundschau - Monatsschrift für die Interessen unserer Schutzgebiete und ihrer Bewohner*, 3, 1914, p. 134.
- 33 Claus Schilling, *Tropenhygiene*, Thieme, Leipzig, 1909, p. 475.
- 34 Peiper, "Der Bevölkerungsrückgang in den tropischen Kolonien Afrikas und der Südsee, - seine Ursachen und seine Bekämpfung", p. 420.
- 35 Ludwig Külz, "Grundzüge der kolonialen Eingeborenenhygiene", *Beihefte zum Archiv für Schiffs- und Tropenhygiene*, 15, 1911, p. 402.
- 36 Ibid., 76.
- 37 Schilling, *Tropenhygiene*, p. 478.
- 38 Lutz D. H. Sauerteig, "'The fatherland is in danger, save the fatherland!' Venereal disease, sexuality and gender in Imperial and Weimar Germany", in Roger Davidson and Lesley A. Hall (eds.), *Sex, Sin and Suffering. Venereal Disease and European Society since 1870*, London - New York, 2001, p. 76.
- 39 Ibid., p. 88.
- 40 For the case of venereal diseases, see Sauerteig, "'The fatherland is in danger, save the

fatherland!’’.

- 41 Grosse, *Kolonialismus, Eugenik und bürgerliche Gesellschaft*, p. 134.
- 42 Ittameier, “Die Erhaltung und Vermehrung der Eingeborenen-Bevölkerung”, pp. 26-27.
- 43 Peiper, “Der Bevölkerungsrückgang in den tropischen Kolonien Afrikas und der Südsee”, p. 434.
- 44 Otto Peiper, “Sozial-medizinische Bilder aus Deutsch-Ostafrika,” *Zeitschrift für Säuglingsschutz*, 1912, pp. 433-4.
- 45 Sauerteig, “‘The fatherland is in danger, save the fatherland!’”, p. 77.
- 46 Halling, Schäfer, and Vögele, “Der Mensch als volkswirtschaftliches Kapita”, p. 399.
- 47 Reichs-Kolonialamt (ed.), *Die deutschen Schutzgebiete in Afrika und der Südsee 1912/13*, Berlin, 1914, p. 78.
- 48 Peiper, “Der Bevölkerungsrückgang in den tropischen Kolonien Afrikas und der Südsee”, pp. 453-4.
- 49 Michael Cowen and Robert Shenton, “The invention of development,” in Jonathan Crush (ed.), *The Power of Development*, Routledge, London, 1995, pp. 27-43.
- 50 See Fanon, *Schwarze Haut, weiße Masken*, p. 23.

Picture Source:

1. [Http://aes.iupui.edu/rwise/countries/GermanEastAfrica.gif](http://aes.iupui.edu/rwise/countries/GermanEastAfrica.gif)
2. [Http://upload.wikimedia.org/wikipedia/commons/b/bb/Bundesarchiv_Bild_10212088_Bernhard_Dernburg.jpg](http://upload.wikimedia.org/wikipedia/commons/b/bb/Bundesarchiv_Bild_10212088_Bernhard_Dernburg.jpg)
3. [Http://www.google.co.in/imgres?imgurl=http://upload.wikimedia.org/wikipedia/commons/thumb/f/f3/Ludwig_K%C3%BCl.jpg/70px-Ludwig_K%C3%BCl.jpg&imgrefurl=http://commons.wikimedia.org/wiki/Category:Ludwig_K%25C3%25BCl&usq=__7FbPiQCYqY6XFriC8F6OJJ59OUQ=&h=119&w=70&sz=3&hl=en&start=3&sig2=2IBXAQoh1IKR_dUhWiv-cg&um=1&itbs=1&tbnid=d-R_SsgUhE9F9M:&tbnh=88&tbnw=52&prev=/images%3Fq%3DLudwig%2BKulz%26um%](http://www.google.co.in/imgres?imgurl=http://upload.wikimedia.org/wikipedia/commons/thumb/f/f3/Ludwig_K%C3%BCl.jpg/70px-Ludwig_K%C3%BCl.jpg&imgrefurl=http://commons.wikimedia.org/wiki/Category:Ludwig_K%25C3%25BCl&usq=__7FbPiQCYqY6XFriC8F6OJJ59OUQ=&h=119&w=70&sz=3&hl=en&start=3&sig2=2IBXAQoh1IKR_dUhWiv-cg&um=1&itbs=1&tbnid=d-R_SsgUhE9F9M:&tbnh=88&tbnw=52&prev=/images%3Fq%3DLudwig%2BKulz%26um%)



Power Disease and Prejudice: A Historiographical Overview of the Syphilis Contagion in Colonial Sub-Saharan Africa, 1890s-1950s



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Power, Disease and Prejudice: A Historiographical Overview of the Syphilis Contagion in Colonial Sub-Saharan Africa, 1890s-1950s

This article maps out the coordinates of literature on syphilis, a major public health concern to colonial administrators, biomedical authorities and mine owners in much of sub-Saharan Africa in the first half of the twentieth century. Colonial responses to syphilis reveal that therapeutic systems and contagion management are not governed exclusively, I argue, by dispassionate scientific considerations that require straightforward pathogen identifications, diagnoses and treatments. Political, economic and cultural factors inform medical questions in complex ways, they influence disease definitions and representations, the choice of therapeutic systems and even their potential reception by society. In much of sub-Saharan Africa the majority of the anti-syphilis programmes and policies were based on prejudicial models that assumed Africans and other social categories on the margins of the privileged white colonial community such as poor whites to be sexual deviants.



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Introduction

The perceived capacity of syphilis to compromise the socio-economic viability and biological health of the African colonies preoccupied European administrators, biomedical authorities and the white public for much of the first half of the twentieth century.¹ Syphilis ceased to be a major public health issue only in the post-Second World War era following the discovery of the antibiotic, penicillin in 1943 and extencillin in the early 1950s. This enabled mass treatment with one single-low cost injection. These therapeutic breakthroughs coincided with the provision of African family accommodation in mining and urban centres as a labour stabilisation mechanism.

The high incidence of syphilis had close connections to the establishment of the colonial capitalist system dependent on male labour migrancy that undermined stable social and sexual relationships in the mines, urban spheres and plantations. Mines and towns' socio-economic milieus of poverty, drunkenness, gender disparities and commercialised sex availed possibilities for high sexual networking. Some male labour migrants translated the traditions of polygamy into having one or more girlfriends in addition to wife or wives left behind in the villages.

Women who subverted the gendered employment and spatial segregation of the colonial state by migrating to colonial commercial centres had few economic opportunities. Some became petty traders and shebeen queens or illicit liquor brewers but for the majority sexual commerce offered a higher degree of financial and social security.² This situation predisposed many men and women to enter transient sexual liaisons conducive for the spread of syphilis and other STIs from these centres of high infectivity to the outlying rural hinterlands.

In the ensuing narrative I explore the empirical concerns, theoretical orientations and sources exploited by scholars who analyse the question of syphilis in Africa. Motives that spurred colonial anti-syphilis interventions ranged from desires for maintaining good national public health profiles; the need for healthy labour that could also reproduce; and fears of racial degeneration and social prejudices against Africans. I conclude by highlighting the silences in the literature and pointing areas for further inquiry in understanding syphilis aetiology in Africa.

'Dangerous' Sexual Networks: Colonial Medicine and the Colonial Political Economy

Pioneering scholarship on syphilis followed the heroic model of health studies that celebrated the triumph of Western biomedicine and technologies in the conquest of pathogens and diseases among Africans. Roy Macleod and Milton Lewis argue that this literature shows that "medicine served as an instrument of empire, as well as an imperializing cultural force in itself."³ The hospital and its associated technologies had to prove to the African that western medicine was superior to their methods of healing. Biomedical authorities and colonial states encouraged missionaries to establish hospitals and dispensaries in African communities partly to aid the government in providing health facilities to indigenous peoples but also to use medical missions as avenues for gaining converts.

Michael Gelfand's analysis of the development of Southern Rhodesia's biomedical service encapsulates this triumphal perspective.⁴ In a period of about forty years Southern Rhodesia created a remarkable health service that "brought the spread of syphilis under control and greatly reduced the frequency of scurvy and pneumonia on its mines, so that by 1939 the former had virtually disappeared and the latter was no longer considered a hazard."⁵ The Southern Rhodesian government also established venereal disease clinics throughout the country starting with Munene in Belingwe (Mberengwa) District 1926. The major drawback with this triumphal literature is its ethnocentric nature; it echoes the colonial state and biomedical authorities' perceptions of African healing systems and strategies to combat diseases

as manifestations of indigenous people's ignorance and primitivism.

Scholars critical of the foregoing heroic model of Western biomedicine in Africa shifted the angle of analysis by exploring the structural conditions of colonial society that abetted syphilis infections. These scholars showed how social dislocation, poverty, disruption of subsistence production and labour migration were responsible for the decline of African health rather than maladjustment to the capitalist contexts and 'immoral' predisposition as claimed by some hysterical colonial commentators.⁶ Although this political economy approach to the study of epidemiology became popular in the 1980s and 1990s,⁷ Sydney Kark had pioneered it through his seminal article, "The Social Pathology of Syphilis among Africans" published as far back as 1949.⁸

Kark identified male labour migrancy to the diamond mines in Kimberly and the gold mines on the Witwatersrand as the major determinant for the transmission of syphilis. Poverty, drunkenness, new sexual mores and social dislocations along with rapid turnover of labour characteristic of mining environments created conditions conducive for the spread of syphilis from mining centres to the outlying African reserves. The most striking feature of mining environments "was that a large group of men were living under abnormal social conditions, because very few, if any, had their wives and families with them. This resulted in promiscuity, prostitution and the sure spread of syphilis."⁹ Mines at times ejected sick miners, thus actively exporting the disease, and making it impossible to complete treatment and trace partners.



Sub Saharan Africa Map

Patrick Harris complements the foregoing by indicating that although syphilis had existed in the Mozambican capital, Laurence Marques, for many years, it only became endemic when carried into the interior by workers returning from South Africa's mining hub, the Witwatersrand, after the 1880s. Syphilis and gonorrhoea proliferated in southern Mozambique with the development of a rootless workforce and a growing market for commercialised sex. In 1887, syphilis crossed the Nkomati River, entered Khosen and within a few years had spread to most of the Delagoa Bay region.¹⁰ Highly infectious, syphilis was greatly feared as it led to infertility, physical disfigurement and death. This exotic disease troubled and confused the Zulus of South Africa and by the 1940s they had no specific name for it other than *isifo sabelungu* (disease of white men) or *isifo sedolopi* (disease of the town).¹¹

Most of the works cited above project syphilis as a disease that exclusively ravaged Africans, while its effects among Europeans is a muted theme. Sidney Sax and Nancy Rose Hunt address this silence by implicating European male soldiers and colonial officials in South Africa and the Belgian Congo for spreading syphilis and other STIs through indulgences with indigenous women. This was particularly the case before World War I, when most Europeans left their wives in Europe and resided in the Congo as single men. Ultimately, doctors encouraged European men to take Congolese steady concubines euphemistically called

menageres or housekeepers.¹² In 1909 the Belgian Congo authorities initiated measures to regulate prostitution by subjecting women who “habitually” and “notoriously” indulged in prostitution in designated European areas to be registered and to undergo bi-weekly medical examinations.¹³ These measures had no parallels in other African colonies but they resonate with contemporary French policies. French anti-syphilis measures were characterised by what Baldwin terms “sanitized copulation” whereby the state legalised and regulated prostitution through designating specific areas for commercial sex and mandating sex workers to undergo regular checks.¹⁴

Colonial economic imperatives spurred the anti-syphilis interventions because the disease compromised the capacity of the Africans to work and reproduce. According to Marks and Anderson, “state officials, the mining industry and whites frequently only expressed concern about ill-health in the African population when this threatened labour supplies or threatened to spread into white areas of town.”

Charles van Onselen makes a deeper exploration of the interior world of mining communities and concludes that mining companies facilitated the spread of syphilis in Southern Rhodesia (Zimbabwe) by tacitly tolerating prostitution as partial compensation to the African men for their prolonged enforced separation from wives and children.¹⁵ From the very earliest days of colonial Zimbabwe’s mining industry *mahure* (prostitutes) were a notable feature of compound life, particularly at big mines such as Cam and Motor Mine, Lonely and Wankie. Mine management and the state alike were unwilling to eliminate *chihure* (prostitution) in spite of its direct contribution to the spread of a deadly disease to the black labour force.¹⁶ Mines in Zimbabwe’s Bulawayo district not only had their resident women within the compound but also had weekend visits of literally truckloads of prostitutes from neighbouring areas. van Onselen indicates that between 1900 and 1933 thousands of workers in the Rhodesian compounds contracted syphilis and about 250 of them died of it.¹⁷

The high incidence of syphilis in the mines and the outlying rural hinterlands triggered official anxieties about population decline due to syphilis-induced sterility and stillbirths. Carol Summers and Hunt argue that these anxieties necessitated the rolling out of widespread antenatal programmes, anti-venereal campaigns and general medicalisation of African societies, particularly in Tanzania, Belgian Congo, Uganda and Southern Rhodesia.¹⁸ Colonial economic imperatives spurred the anti-syphilis interventions because the disease compromised the capacity of the Africans to work and reproduce. According to Marks and Anderson, “state officials, the mining industry and whites frequently only expressed concern about ill-health in the African population when this threatened labour supplies or threatened to spread into white areas of town.”¹⁹

British concerns over high syphilis infections and the corresponding declining reproductive capacities of indigenous populations in Uganda intensified from 1907 through 1924. Authorities developed institutions and ideologies to cope with the epidemic by promoting the family as a unit of reproduction and reforming motherhood through the efforts of midwives trained by Maternity Training School (MTS). This anti-syphilis regime began as a basic medical attempt to treat the ill. After the First World War ‘social hygiene’ became an important therapeutic tool and the administration worked to instil shame and to change the sexual behaviour of individuals. They discouraged polygamous marital relations and alcoholism. Authorities argued that men suffering from the effects of alcohol or venereal diseases often failed to report to work or adequately perform their duties.

In Zambia, the British had a slightly different anti-syphilis programme characterised by what Bryan Callahan terms enlightened policies that reduced the stigma of STIs at an early

stage. These entailed preventive education and labour stabilisation measures that permitted African men to move to the Copperbelt mines with their wives. They also put elaborate systems of medical surveillance that explain why STIs were not such serious worries to the administration as in the Southern Rhodesia and South Africa.²⁰

The syphilis upsurges at times resulted in ironic collusions between African men and European officials to control African women's mobility and relations as a way controlling the disease. This theme is well analysed by McCulloch and Maryinez Lyons in the cases of colonial Uganda and Zimbabwe respectively. State and biomedical authorities invariably labelled such women who moved into mining and urban environs as 'stray,' 'floating,' and 'peripatetic'.²¹ This shows how women's bodies and reputations became central to the maintenance of social order in colonial Zimbabwe. In colonial Uganda Europeans and African men agreed that the loss of social control and resulting immorality was a major reason for the spread of STIs. The control of women and moral standards became the catchwords of the STI campaign. Black South African and Southern Rhodesian men supported curbs on female entry to urban areas between the 1920s and 1950s.

These men argued that urban and mine based women were violating moral order by indulging in prostitution and spreading sexually transmitted diseases. Among the most vocal organisations that lobbied the colonial state to push women out of mines and towns and to impose stringent measures against their entry into urban spheres were the Manica Cultural Society and the Amandebele Patriotic Society.²² However, spatial segregation and the confining of women in rural areas failed as some women sneaked their way into urban areas and mining centres.

The high prevalence of syphilis in mining compounds and urban areas triggered also the use of state power under the guise of medical exigency.²³ Colonial governments passed repressive legal instruments that gave colonial authorities power to physically examine Africans. Those found infected were legally required to undergo treatment. These laws were a replica of England's much hated Contagious Disease Acts of the late nineteenth century that were enacted to control venereal disease, prostitution and immorality. In Zimbabwe, anti-venereal disease inspections, *Chibheura*, largely targeted women. *Chibheura* (literally, to open up) were used by colonial authorities to examine women coming into mining and urban areas. Since African women were not formally incorporated into the colonial economy these examinations of women's bodies "was for their potential to infect African men with venereal disease and, to a lesser degree, for their potential to infect European men (who, everyone knew, consumed their sexual services and, when Europeans began hiring African women as nursemaids, European children)".²⁴ These intrusive colonial public health campaigns were often insensitive to questions of human rights and cultural sensibilities and they discontinued in 1958 because of the growing militant African opposition. Africans expressed displeasure against this differential epidemiological targeting through demonstrations, threats of violence, and petitions to colonial state authorities. In the following section I explore how medical knowledge and power were used to control the Africans.

Medicine, fantasy and prejudice in Africa: Combating a disease that did not exist

Recent scholarship by historians and other social scientists such as Megan Vaughan, Callahan and Karen Jochelson focuses on the social construction of medicine and medical knowledge.²⁵ Their core postulation is that medical knowledge is not just a reflection of an empirical, biological reality independent of a social context and attitude. Susan Cradock argues that disease is often used in societies to intensify the rhetoric of hatred, fear, and blame against

undesirable populations.²⁶ In most instances such rhetoric shifts from the “socially constructed to the medically legitimated, from a vaguely if forcefully defined rationale of difference to a rational basis for surveillance, control, and exclusion.”²⁷ The fact that syphilis is acquired through sex and to some extent multiple partner sexual behaviour also means that societies often take puritanical interests in the disease and thus infect discussion of it with all sorts of non-medical considerations.

Many colonial authorities and the white community blamed Africans in general for their purported reckless sexuality or cultural values such as polygamy that abetted the spread of the disease. Colonialists believed Africans to be ignorant, irresponsible, highly sexed and disease-ridden. These stereotypes interlocked with existing beliefs about irrepressible female sexuality, particularly that of black women. These prejudices pushed colonial Zimbabwe’s community groups, professional associations, and local councils to force the department of health in the 1920s into combating what Jock McCulloch calls a “threat which did not exist.”

In many societies the poor, the alien, the sinners have served as convenient objects for such stigmatising medical speculations. In the United States Haitians, the Chinese, Africans, gays, and slum dwellers have been accused at one point or another of spreading diseases. Dorothy Nelkin and Sander Gilman explain this tendency to label and exclude groups on the margins of social structures by arguing that “men and women have tended to reduce their sense of vulnerability in times of plague by defining others as the ailment’s appropriate and likely victims, creating reassuring frameworks in which to control and disarm otherwise disconcerting realities.”²⁸

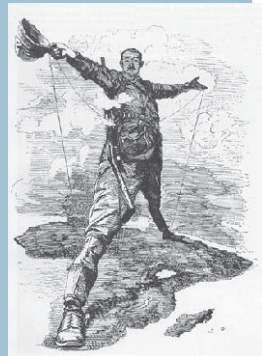
Many colonial authorities and the white community blamed Africans in general for their purported reckless sexuality or cultural values such as polygamy that abetted the spread of the disease. Colonialists believed Africans to be ignorant, irresponsible, highly sexed and disease ridden. These stereotypes interlocked with existing beliefs about irrepressible female sexuality, particularly that of black women. These prejudices pushed colonial Zimbabwe’s community groups, professional associations, and local councils to force the department of health in the 1920s into combating what Jock McCulloch calls a “threat which did not exist.”²⁹

McCurdy elaborates on the linkages between white prejudices and misinformed diagnoses and wrong policies to combat the syphilis problems in African societies. In colonial Uganda the British embarked on propaganda efforts aimed at educating adults. This began with the publication of a special series of articles in the Swahili newspaper, *Mambo Leo*, which linked alcohol use to immorality and venereal disease. The morality campaign’s attack on Manyema women’s dance competitions linked colonial fears of independent women to colonial concerns about the survival of the labor force. When they blamed dancing women for creating a space for drinking and immoral, illicit, and diseased acts of sexual debauchery, British colonial administrators simultaneously accused them of spreading venereal disease. Authorities also thought that decreasing fertility rates among Manyema women were induced by syphilis. This view was flawed because the real reason was that the women deliberately controlled their reproduction as a result of the economic difficulties that they faced, particularly in the context of the tough economic condition of the 1930s.

Callahan makes similar conclusions in his examination of the history of a well-known 1940s syphilis epidemic among the Ila-speaking people of Northern Rhodesia’s Namwala District.³⁰ He argues that the epidemic was largely a colonial construction based on a misinterpretation of the role of sex in Ila exchange relations and an underassessment of other factors that may have contributed to the perception that population growth was stagnant. Colonial officials used poor census taking mechanisms that gave the wrong impression of

population decline.³¹ European observers tended to view Namwala ‘natives’ as excessively libidinous, particularly in view of *lubombo* rituals and sexual entrapment called *kuweza lubomo*, or ‘cattle catching,’ in which a wife, with the encouragement of her husband, deliberately seduces another man.³² As a result, they often misinterpreted the presence of various endemic disease conditions as virgin-soil outbreaks of syphilis. The British ignored the demographic impact of other infectious diseases, malnutrition disorders, and consciously deployed birth control measures. Due to migration of labour people were also delaying marriages and this had a negative bearing on birth rates. Colonial authorities also confused syphilis with yaws, a disease that has similar clinical appearances to syphilis.

Cecil John Rhodes, the architect of British imperialism in Africa



Colonial authorities at times identified and targeted specific categories such as the so-called “wicked”, “native travelling prostitutes” or “loose town women” as vectors of syphilis. From the 1880s to the 1950s, South African authorities also targeted “half castes” and poor whites as responsible for spreading syphilis. Jochelson argues that these people came to embody the essence of diseases and social corruption because their poor way of life undermined the colonial foundational notions of white superiority.³³ These people threatened social norms and blurred social hierarchy and one can argue that syphilis provided a social template for expressing colonial power and racial difference through the pathologisation of Africans and other marginalised social categories by colonial whites.

These notions of racial invincibility, purity and superiority were popular in nineteenth and early twentieth century Europe, where they informed and influenced the metropole’s anti-venereal laws. According to Philipa Levine, the United Kingdom’s constructions of sexuality and disease were shaped by strong concerns about “racial degeneration.” This prompted conflicting fears of “natives” and uncontrolled “female sexuality.”³⁴ As result of these fears prostitution was seen as a throwback to “primitivism” and a threat to British racial pre-eminence. Levine observes that:

Since VD rates in colonial settings were often higher, in part because the white community in the empire was predominantly male-and often military and unmarried-the issue came to have significant imperial overtones. The spread of disease was potentially ruinous to Britain’s powerful empire as well as to its alleged racial superiority.³⁵

Within the same framework of the interface between race and disease, other scholars like Bland Lucy and Gilman argue that the growth of eugenics and Social Darwinism ideas motivated anti-syphilis laws.³⁶ Interest in physical characteristics, particularly those associated with racial difference began to inform concepts of health and aesthetics. Westerners also started defining “Others” in terms of sexual pathology.³⁷ Therefore, anti-syphilis laws in the United Kingdom were not just informed by the desire for good health among citizens but by anxieties of degenerating into the colonised and supposedly inferior ‘others’.

Although the social constructionist paradigm reveals that colonial intervention strategies in disease control were informed more by perception than reality, the approach ignores indigenous ways of dealing with epidemics. This is because of the overriding concern with showing the interface between colonial power and prejudice evident in colonial discourses that projected 'native' bodies as diseased and maladjusted to the modern world of capitalism. Colonial authorities and anthropologists also viewed Africans as sexually permissive and libidinous beings. African views of sexual mores and responses to syphilis are silenced in their narratives because they largely rely on the colonial archive. Social constructionists highlight the European prejudices against Africans but do not interrogate and deconstruct the fallacies that fed into these prejudices.

African Coping Strategies and Silences in Syphilis Research

Although syphilis was exotic to the African disease ecology, Africans devised coping strategies both at the workplaces and the rural areas. These entailed adjustments of therapeutic regimes, condemnations of multiple sex partnerships and indulgence of miners in same sex relations. These adjustments confirm Steven Feierman's observations that change in disease and in the basic organisation of everyday life necessarily lead to changes in the measures people make to preserve health and healing practices.³⁸ Measures devised by Africans in response to syphilis did not merely occur as incidental developments, they were results of conscious reflections and creativity. Some of these measures have not received much scholarly attention, thus I will highlight insights from my findings from archival and oral research done in Zimbabwe.



African Miners and White Supervisors

Marc Epprecht and T. Dunbar Moodie postulate that commonplace transient homosexual relationships (*hongochani* in Shona or *ngotshana* in Zulu) among African miners developed in order to avoid indulgence with disease-ridden mine 'prostitutes'. These *ngotshana* relations enabled the men to steer clear of demanding women and children in town and the dangers of death or mutilation at the hands of rival men for those women in the townships.³⁹ This view is also affirmed by Van Onselen's claim that around the 1910s in the Witwatersrand a notorious gang leader, Nongoloza, alias Jan Note, passed a startling decree for his men to have sex with each other or with "boy servants" rather than with women.⁴⁰ The intention in so doing was to protect urban gang members from sexually transmitted diseases.

According to Patrick Harries, Mozambican migrants tried to control the sexual behaviour of their women in the rural areas by paying a 'protective fee' to their fathers, brothers or heirs.⁴¹ This overseer role was known as *basopa* or *fanagalo* from the Afrikaans expression "to watch." In the Eastern Cape in the interwar years, some men appointed a male substitute to offer intercrural sex to their wives during their absence, thus gratifying and safely channeling sexual desires of their wives and controlling their fertility.

Contrary to the perceptions of unrestrained sexuality among Africans embedded in most of the above cited works Africans could have controlled syphilis by using age-old mechanisms for preventing promiscuous relations. For example, many traditional African communities were not sexually permissive and marital fidelity was highly regarded. This even included people in polygamous marriages. Failure to do so would result in tragedies such as the death of the husband or a child. Ezekiel Kalipeni and Joseph Oppong note that among the Chewa of central Malawi, Zambia, and parts of Mozambique a disease called *tsempho* ensured sexual restraint. This is a potentially fatal wasting disease attributed to immoral sexual relationships during prohibited periods.⁴²

The Shona people in Zimbabwe used the *runyoka* medicines to prevent sexual incontinence. Gordon Chavunduka calls such medicines “instruments of law and order or for the preservation of morality.”⁴³ Husbands who suspected their wives of cheating could put such medicines in the conjugal bed in order to trap or harm the paramour. In some cases a husband spiked his wife’s drink or food with some medicine that cause her lover to develop a terrible itch all over his body as though he were covered by ants. There are possibilities that some Shona labour migrants used this *runyoka* system as mechanism to safeguard marital fidelity and simultaneously as an anti-syphilis strategy.

Although the colonial state in Zimbabwe established anti-venereal disease clinics in many parts of the country, former miners relied largely on providers of traditional therapy, especially herbalists, for their anti-syphilis remedies. These mine workers consulted biomedical authorities only in cases of extreme infection. For ‘ordinary’ infections many former migrant labourers indicate that “*vanhu vatema tairarama nemiti*” (“as black people we survived on herbs”) provided by herbalists.⁴⁴ These herbalists were ordinary people who had acquired an extensive knowledge about the medicinal qualities of trees and herbs without having the occult powers associated with traditional healers. In most cases they tended to be old men and that is still the case today.⁴⁵ The surreptitious nature of the herbalists’ ways of treating STIs made them popular with African workers. Workers assumed herbalists ‘respected’ patient confidentiality and were ‘friendlier’ compared to hospitals and clinics where doctors and nurses ‘forced’ STD patients to bring their partners along for treatment and counseling.⁴⁶

It appears that the consultation of herbalists by African workers was also prompted by fear of dismissal from employment. Mine owners had a tendency of dismissing infected workers. These arbitrary dismissals violated the Mine and Works Act of 1911 that prohibited mine owners from terminating workers’ contracts on the basis of sickness. Employers were supposed to provide good health facilities for their workers. Medical authorities and state officials regularly complained against worker dismissals by mine owners. The Medical Director was quite vocal about his objections to the dismissal of infected workers.⁴⁷ Archival records in Zimbabwe hardly show colonial authorities prosecuting mine owners for dismissing infected workers. Employer’s liberal dismissals of infected employees compelled African workers to seek medical recourse in alternative therapeutic systems. Some of the former mine workers do not view these dismissals as violations of their labour rights, they use ‘cultural idioms’ to rationalise actions of mine owners. Many indicate that the dismissals were caused by the belief that “*njovhera inovhara mukute*” (“STIs blocked mineral seams in the mines”).

In the mines, both mine owners and African workers negotiated new meanings about sex and sexuality that served, either deliberately or inadvertently, as anti-syphilis measures. For example, ‘mine lore’ evident in many Zimbabwean former migrant labourers’ narratives indicates that women were excluded from working in the mines because of the belief that “*vakadzi varikumachira vaivhara mari*” (“the presence of menopausal women in the mines

resulted in the disappearance of gold seams”).⁴⁸ This perspective appears to have been a ‘invention of tradition’ within the mines because in pre-colonial African societies women were involved in most mining processes. This ritualised exclusion of sexually active women from mining spaces served to contain the spread of STIs in the mines. The exclusion of women also ensured that they remained confined in the rural areas reproducing future generations of African workers at no cost to the colonial employers. The continued existence of women in the rural hinterland helped African men to retain a foothold in these areas by safeguarding their access to land.

Besides the use of traditional therapies some African workers challenged the colonial state’s spatial segregation laws that prevented them from bringing their wives into the mines by temporarily settling them in the vicinities of mines. This was in an effort to maintain close marital relations that limited chances of extramarital liaisons. Migrant labourers from neighbouring countries such as Zambia and Malawi largely resorted to these measures because it was impossible for them to go back to their home countries to see their wives and children. Foreign-born migrants married to local women also negotiated with local indigenous authorities for places to establish homes within Zimbabwe

Conclusion

In the foregoing review I have tried to identify the motivations of diverse ‘colonial agents’ such as government officers, biomedical authorities, mine owners and missionaries in resolving the syphilis problem. These included a complex interplay of labour requirements, concerns about declining fertility, and irrational fears of whites about Africans as inherently diseased. However, there remain significant gaps in scholarly analyses of the syphilis problem. African perceptions of syphilis aetiology and therapeutic practices as well as meaning making, perspectives on syphilis and self-defined experiences of miners and commercial sex workers remain suppressed histories. African ‘voices’ and agency have to be placed at the centre of anti-syphilis discourses and practices. This can be done by exploring how they adjusted their diagnosis and treatment of syphilis and negotiated safe sex and faithful monogamous relationships.

- 1 See annual reports of Native Commissioners for colonial Zimbabwe, particularly from 1900 to the 1920s.
- 2 See Louise White, *The Comforts of Home: Prostitution in Nairobi*, The University of Chicago Press, Chicago and London, 1990.
- 3 Roy MacLeod and Milton Lewis, quoted in Shula Marks, “What is Colonial about Colonial Medicine? And What has Happened to Imperialism and Health”, *The Society for the Social History of Medicine*, 1997, p. 207.
- 4 Michael Gelfand, *A Service to the Sick: A History of the Health Services for Africans in Southern Rhodesia, 1890-1953*, Mambo Press, Gweru, 1976.
- 5 Ibid, pp.17-18.
- 6 See, Jock McCulloch, *Black Peril, White Virtue: Southern Crime in Southern Rhodesia, 1902-1935*, Indiana University Press, Bloomington, 2000.
- 7 Randall Packard, *White Plague Black Labor: The Political Economy of Health and Disease in South Africa*, University of California Press, Berkeley, 1988; Shula Marks and Neil Anderson, “Issues in the Political Economy of Health in Southern Africa,” *Journal of Southern African Studies*, 13,2, 1987. Special Issue on the Political Economy of Health in Southern Africa.
- 8 Sydney L.Kark, “The Social Pathology of Syphilis among Africans,” *South African Medical*

Journal, volume 23, 1949, pp. 77-87.

9 Ibid, 77.

10 Patrick Harris, *Work, Culture and Identity: Migrant Laborers in Mozambique and South Africa*, Heinemann, Portsmouth, 1995, pp. 155-156.

11 Kark, "The Social Pathology of Syphilis".

12 Sidney Sax, "The Introduction of Syphilis into the Bantu Peoples of South Africa", *South African Medical Journal*, Volume 26, 1952, pp.1037-1039; Nancy Rose Hunt, "STDs, suffering, and their derivatives in Congo-Zaire: Notes towards an historical ethnography of disease", available on codesria.org/IMG/pdf/06LHUNT_.pdf, accessed on 03.05.2010.

13 Hunt, "STDs, Suffering and their Derivatives".

14 Peter Baldwin, *Contagion and the State in Europe, 1830-1930*, Cambridge University Press, Cambridge, 2005, pp. 358.

15 Charles van Onselen, *Chibharo: African Mine Labor in Southern Rhodesia, 1900-1933*, Ravan Press, Johannesburg, 1980, pp. 175-76.

16 Ibid. p. 49.

17 Ibid.

18 Carol Summers, "Intimate Colonialism: The Imperial Production of Reproduction in Uganda, 1907-1925", *Signs*, 16, 4, 1991; Sheryl A. McCurdy, "Urban Threats: Manyema Women, Low Fertility, and Venereal Diseases in Tanganyika, 1926-1936", in Jean Allman, Susan Geiger, and Nakanyise Musisi, eds, *Women in African Colonial Histories*, Indiana University Press, Bloomington Indiana, 2002, p. 221; Nancy Rose Hunt, *A Colonial Lexicon of Birth Ritual, Medicalization and Mobility in the Congo*, Duke University Press, Durham and London, 1999, pp. 250-268.

19 Marks and Anderson, "Epidemics and Social Control in Twentieth Century South Africa," *The Society for the Social History of Medicine*, 34, pp. 32-34.

20 Bryan T. Callahan and Virginia Bond, "The Social, Cultural, and Epidemiological History Sexually Transmitted Diseases in Zambia," in Philip W. Setel, Milton Lewis and Maryinez Lyons, eds, *Histories of Sexually Transmitted Diseases and HIV Aids in Sub-Saharan Africa*, Greenwood Press, Westport, Connecticut, 1999.

21 Lynette A. Jackson, "'When in the White Man`s Town`: Zimbabwean Women Remember *Chibheura*", in Allman, Susan Geiger, and Nakanyise Musisi, (eds.), *Women in African Colonial Histories*, 2002, pp. 96-107.

22 Elizabeth Schmidt, "Negotiated Spaces and Contested Terrain: Men, Women and the Law in Colonial Zimbabwe, 1890-1939", *Journal of Southern African Studies*, 16, 1990.

23 Jackson, "'When in the White Man`s Town'", pp. 96-107; McCurdy, "Urban Threats: Manyema Women", pp. 220-223.

24 Carol Summers, "Intimate Colonialism: The Imperial Production of Reproduction in Uganda", p. 193.

25 Vaughan, *Curing their Ills: Colonial Power and African Illness*, Stanford University Press, Stanford, 1991, pp. 1-25 and 129-152; Karen Jochelson, *The Color of Disease: Syphilis and Racism in South Africa in South Africa, 1880-1950*, Palgrave, Oxford, 2001. See also Joch McCulloch, *Black Peril, White Virtue*.

26 Susan Craddock, *City of Plagues: Disease, Poverty, and Deviance in San Francisco*, University of Minnesota, Minneapolis, 2000, p. 4.

27 Ibid.

28 Dorothy Nelkin and Sander L Gilman, "Placing Blame for Devastating Disease", in E. Fee and D.M. Fox, (eds.), *AIDS: The Burdens of History*, University of California Press, Los Angeles and London, 1998, p. 148.

- 29 Ibid, p.192.
- 30 Bryn Callahan, “‘Veni, VD, VICI’?: Reassessing the Illa Syphilis Epidemic”, *Journal of Southern African Studies*, 23, 3, 1997.
- 31 Ibid, p. 42.
- 32 Ibid, p. 45.
- 33 Jochelson, *The Color of Disease*.
- 34 See Phillipa Levine, “Venereal Disease, Prostitution and the Politics of Empire: The Case of British India”, *Journal of The History of Sexuality*, 1994, pp. 579-602; Phillipa Levine, *Prostitution, Race and Politics: Policing Venereal Disease in the British Empire*, Routledge, New York and London, 2003; Ann L Stoler, “Making Empire Respectable: The Politics of Race and Sexual Morality in Twentieth Century Colonial Cultures”, *American Ethnologist*, 16, 1989, pp. 634-660.
- 35 Phillipa Levine, *Prostitution, Race and Politics*, p. 2.
- 36 Sander L Gillman, *Sexuality: An Illustrated History -Representing the Sexual in Medicine and Culture from the Middle Ages to the Age of AIDS*, Wiley, New York, 1989; Bland Lucy, “Guardians of Race, or Vampires upon the nation’s health? Female Sexuality and Its Regulation in Early Twentieth Century Britain”, in E. Whitelegg, (ed.), *The Changing Experience of Women*, M Robertson, Oxford, 2002. pp. 373-88.
- 37 Gillman, *Sexuality: An Illustrated History*.
- 38 Steven Feierman, “Struggles for Control: The Social Roots of Health and Healing in Modern Africa”, *African Studies Review*, 28, 2/3, 1985, p. 12.
- 39 Marc Epprecht, *Hungochani: The History of a Dissident Sexuality in Southern Africa*, McGill and Queen’s University Press, Montreal and Kingston, 2004; T Dunbar Moodie (with Vivienne Ndatshe and British Sibuyi), “Migrants and Male Sexuality on the South African Gold Mines”, *Journal of Southern African Studies*, 14, 2, 1988.
- 40 Charles Van Onselen, *The Small Matter of a Horse: The Life of ‘Nongoloza’ Mathebula, 1867-1948*, Ravan Press, Johannesburg, 1984. p.15.
- 41 Harris, *Work, Culture and Identity*.
- 42 Joseph R. Opong and Ezekiel Kalipeni, “Perceptions and Misperceptions of AIDS in Africa”, in Ezekiel Kalipeni, Susan Craddock, Joseph R.Opong, and Jayati Gosh, (eds.), *HIV and AIDS in Africa: Beyond Epidemiology*, Blackwell Publishing Limited, Malden, 2004, p. 51.
- 43 Gordon L. Chavunduka, *Traditional Medicine in Modern Zimbabwe*, University of Zimbabwe Publications, Harare, 1994, p.77.
- 44 Interviews with Magiya Ndlovu and David Nyambuya.
- 45 Ibid.
- 46 Interview with Jeffries Moyo, Shabani Mine, Zvishavane, 16 June 2007.
- 47 NAZ H2/3/8/1, Medical Director to the Secretary, Rhodesia Small Worker’s and Tributators’ Association, 25 May 1923.
- 48 Interview with Peter Sakala, Zhombe, Midlands Province, 14 June 2007.

Picture Source:

1. http://www.runforafrica.com/yahoo_site_admin/assets/images/Africa-map-e.343175509.gif
2. <http://www.africaheritagerivonia.com/wp-content/uploads/2010/01/Post-colonial-Africa.jpg>
3. <http://www.scientificamerican.com/media/inline/blog/Image/Colonial-Africa-HIV.jpg>

Venerereal Diseases and Race in Early Twentieth Century Peru¹



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Venereal Diseases and Race in Early Twentieth Century Peru¹

This paper examines a particular dimension of the formation of biomedical knowledge on venereal disease (VD) in Peru in the late nineteenth and early twentieth centuries: Its profound racialisation. I argue that the understandings of Peruvian medical doctors' about VD were intimately linked to their understandings of race and in particular to the racial anxieties that resulted from the belief that VD reflected and in turn contributed to racial degeneration.



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In Peru as elsewhere, biomedical attention to venereal diseases (VD) in the late nineteenth and early twentieth century overlapped with a broader, i.e. 'non-medical', preoccupation with gonorrhoea and particularly syphilis. As numerous studies show, like few other diseases, in the nineteenth and early twentieth centuries commentators connected VD to prevalent anxieties over aberrant sexual behaviour and social and racial degeneration in a broader context of perceived uncontrolled, and possibly uncontrollable, social and political change.² At the same time, and partly as a consequence of the introduction of more effective diagnosis and treatment, VD treatment emerged as a field in which policy makers, in alliance with physicians, could play a key role in moral and social governance. However, as Davidson and Hall note in their survey of the historiography of VD in Europe, "responses to VD have always been powerfully inflected by local and historical contingencies".³ In tsarist Russia, Laura Engelstein has suggested, physicians viewed syphilis as expressive of the broader dangers that the increasing "westernisation" of their society entailed.⁴ In South Africa, Karen Jochelson argues, "medical discourse on VD drew on evolutionary theory, sociology or social anthropology to help explain why 'half-castes', poor whites, white 'amateur prostitutes', Africans and 'loose town women' spread VD and in doing so confirmed theories about racial difference".⁵ In Peru, I argue in this paper, the making of medical knowledge on VD was intimately tied to the racialised understandings of the character of the Peruvian population prevalent among medical doctors.



Dos de mayo-

In 1888, the medical journal *Monitor Médico* reproduced the thesis that Julian Arce, a medical student, had read out in Lima's medical faculty in order to graduate. The title of the thesis was "Radezyge", which Arce explained was the name the Danes gave to a form of tertiary syphilis ("it derives from two Danish words, rada which means bad, filthy, and zige which means disease").⁶ Arce's choice of the Danish term to refer to the form of syphilis he had observed among a small number of patients in the Dos de Mayo hospital points to the restricted sources of medical knowledge on VD upon which he, and presumably others, could draw, and to a hierarchical order that shaped medical instruction in late nineteenth century Lima. As Arce noted, in a tone which does not suggest that he saw such a procedure as inadequate, "in order to achieve my objective I have consulted only the sources provided by my master Dr. Villar and those included in a monograph on this disease published in 1860 by Professor Broeck of Christiana".⁷ Arce explained that the disease had first manifested itself in Norway following the arrival of a Russian ship carrying "gente desordenada" [people of loose morals] who then gave the disease to Norwegian women. The disease spread rapidly and inexorably, despite the various attempts by medical authorities to block its transmission. Arce noted that although early diagnoses attributed the evolution of the disease to the cold climate and to poor nutrition, most students of the disease agreed that its principal source of transmission was "the essentially syphilitic nature of this disease and the dreadful health and hygiene of these individuals"⁸ to

which was added the general resistance of those afflicted to reveal their condition, even to physicians.

Arce concluded from his preliminary studies that radezyge was caused by a syphilitic infection. But, he added, its manifestation also owed to a series of predisposing factors: “loose living, lasciviousness, the failure to observe the most basic precepts of Hygiene.”⁹ He noted that his observations revealed that the disease was prevalent primarily among Asians in Lima. This was not surprising: By virtue of their “vida desordenada” [loose living], Asians were in “natural” contact with Lima’s infected population. Arce speculated that it was likely that radezyge had arrived in Peru much as it had arrived in Norway, that is, carried by undesirable migrants. It followed that unless measures were taken radezyge could easily be spread by the Asian migrants in the city. Recent visits to Chinese establishments, and particularly to the Chinese theatre, had convinced Arce that it would constitute the principal source of radezyge infection in the city:

(I)n a small space, divided and subdivided as many times as it is physically possible, on five or six floors, in innumerable rooms, coves, bunk beds, mattresses, etc. live constantly hundreds of people of both sexes, engaged in all the vices in the most heightened state of sleaziness and abandonment. In this poorly ventilated place, there reigns an opiated atmosphere, heavy with the emanations of those individuals who inhabit it and those produce by the effluent, which the absence of drains keeps blocked. Add to this finally... that even when ill... they continue in this style of life with a certain danger for those around them, then it is not venturesome to assert that where radezyge to spread in this city, particularly in epidemic form, this place would be its largest and principle source of contagion.¹⁰

As Arce’s thesis suggests, at the turn of the twentieth century physicians’ views on the effects of syphilis on Peru were highly racialised. Typically Asian and particularly Chinese migrants were blamed for the spread of VD. In 1901, for example, a physician blamed the ‘depopulation’ of Lima on Asian immigrants who were largely responsible, he suggested, for the spread of hereditary syphilis on the grounds that all five syphilitic children he had observed in the past month were ‘sons of Chinamen and local mestizas’: “If, when he is healthy, the Chinaman engenders degenerate sons in most cases, what will happen when he transmits, hereditarily, the diseased germs that produce syphilis?”¹¹ These anxieties regarding the links between syphilis and racial degeneration are similarly evident in the first systematic study of syphilis in Lima, a thesis defended by Alfonso Pasquel in 1911 at Lima’s medical faculty.¹² Although he claimed to be presenting a mere statistical exercise, it is significant that Pasquel devoted considerable time and space to analysing the degree of syphilis morbidity and mortality of each race in the capital. His statistical analysis revealed that out of 80,948 patients treated at the Dos de Mayo and Santa Ana hospitals, some 1,027 were syphilitics. Significantly, although morbidity was higher among men (668 syphilitics from a male sample of 43,650; 359 from a female sample of 37,298), mortality was higher among women, with 75 deaths as opposed to only eighteen male deaths. Pasquel explained the higher female mortality by noting that “in our country, there is little doubt women bear the brunt of the struggle for life”, having to take care of their husbands, home and children, and thus typically only sought hospital treatment when the illness was already well advanced. By contrast, the sexual promiscuity and vigour of the male sex meant that males were more resistant to the effects of syphilis and, ‘because he is more selfish’, sought hospital treatment sooner.

In keeping with the bulk of scientific writing of the time, Pasquel’s analysis was profoundly racist and white supremacist. The white race, Pasquel noted, ‘the best endowed, has

and will always have, a supreme and primary role in the human family'.¹³ Although never made explicit, Pasquel's study reveals white/creole anxieties concerning the racial implications of the spread of syphilis for the Peruvian nation. Pasquel concluded that of the five racial groups, Indians were the least affected by syphilis, followed by the 'yellow race', mestizos, whites and most affected of all, blacks.¹⁴ However, it was the high incidence of syphilis among whites and the low incidence among Indians that particularly concerned Pasquel. He interpreted the high incidence among blacks as a confirmation that the black race "tends to disappear", a common theme in contemporary racial thinking. By contrast, the low incidence among the Asian population surprised Pasquel, leading him to note that "the Chinese, given their addictions and corruptions, do not exhibit the morbidity that one would expect, since they are intoxicated by opium and eliminated by tuberculosis"¹⁵. The high incidence among whites was put down to a combination of factors, including the "conspiracy of silence"¹⁶ between infected males and doctors, and the costs of marriage, which meant that most men became sexually active before they were in wedlock and as such resorted to prostitutes for sexual gratification. The low morbidity among Indians, meanwhile, owed not, as suggested by other scholars, to the absence of casual sexual relations in indigenous culture— Pasquel contended that Indians were as sexually promiscuous as the other races— but rather, although this idea was put forward tentatively, to the fact that they had developed some degree of resistance to infection.

In addition to blaming VD 'diffusion' on "intersexual and nutritional venereal contact", Gamio blamed the climate "which produces a hedonist sexual hyperesthesia in man" and "the hybrid heredity [herencia] which has produced largely negative results as a consequence of the mixing of heterogeneous sub-races" and, finally, the "preponderance of sensualism" which he blamed on both the climate and on the country's negative heredity and which he saw everywhere he looked - "in conversations, in customs, in dress, in the caricatures painted on the walls of houses, in the secluded rooms of restaurants, in hotels, hospitals and clinics".

Some thirty years later, a similarly highly racialised reading of VD, now inflected by eugenic concepts, appeared in Peru's flagship medical journal, *La Crónica Médica*. Dr. Enrique Gamio's 1943 article titled "Geo-Social and Ethnic Factors of Propagation of Venereal Diseases" established in no uncertain terms a correlation, indeed a causal relation, between Peru's suboptimal racial make-up and the spread of VD.¹⁷ Gamio began by listing what he considered to be Peru's 'national problems', namely "depopulation, the absence of a single ethnic type, the absence of a national consciousness, the scarcity of civilised ethnic groups, racial mixing (hibridación) in the populated centres of the coast, and the lack of strong migration flows".¹⁸ For Gamio both Peru's hot climate and its 'racial poverty' were factors that needed to be taken into account in order to explain the country's 'social diseases'. Whereas 'Saxon America' and most of Peru's neighbours had taken 'efficient and determined' 'sociological and geo-political' steps to develop an 'advanced scientific culture' through the implementation of eugenics and hygiene, Peru had yet to do so. Gamio suggested that if Peru's statesmen failed to address the deficiencies that arose from the country's climate and racial make-up from a 'biological' perspective, the country would become vulnerable to conquest by a foreign power. Gamio identified the spread of 'venereopatías' (venereal diseases) among what he called the 'civilised and semi-civilised populations' of the country as both a consequence of, and a contributor to, Peru's climatic and racial deficiencies. Thus in addition to blaming VD 'diffusion' on "intersexual and nutritional venereal contact", Gamio blamed the climate "which produces a hedonist sexual hyperesthesia in man" and "the hybrid heredity [herencia] which has produced largely negative results as a consequence of the mixing of heterogeneous sub-races" and, finally, the "preponderance of sensualism" which he blamed on both the climate and on the

country's negative heredity and which he saw everywhere he looked - "in conversations, in customs, in dress, in the caricatures painted on the walls of houses [*sic.* possibly refers to graffiti], in the secluded rooms of restaurants, in hotels, hospitals and clinics".¹⁹ Further factors that Gamio identified as contributing to the spread of VD included the absence of sex education and of "protection for the family" and the system of regulation that ordered prostitution in the country.

Gamio put forward a series of recommendations to address the spread of VD, which echoed those put forward by many of his contemporaries, that reflect both disciplinary and biopolitical rationalities.²⁰ They included compulsory sex education "according to eugenic and hygienic norms" in schools, the abolition of the system of regulated prostitution (which created licensed brothels and subjected prostitutes to a regime of medical policing), and the creation of gyms, gardens, and educational cinemas. But Gamio also favoured the passing of a law criminalising venereal contagion along the lines established by the Mexican penal code. However, Gamio went on to make recommendations that reflected his belief that the spread of VD was the consequence of Peru's inferior racial make-up and particularly of the 'hybrid' nature of its populations. In outlining the "Prejudices that conspire against human capital in Peru", Gamio revealed his own racial and class prejudice: He argued that "xenophobia towards homogeneous foreign races" hindered the strengthening of the Peruvian race, and that Peruvian race, like cattle, would benefit from being crossed with "strong and healthy foreign races" (clearly, this was a hybridity which he did approve). He stressed similarly that 'humble people', by which he meant the poor, believed that in order to be real men they needed to have venereal diseases and to favour a life of alcoholism, carnal pleasure, and the frequenting of brothels. By contrast they deemed effeminate anyone who was orderly, looks after his physical, moral and mental, health and practices sexual hygiene by avoiding VD. In short, Gamio concluded, 'racial hybridity' and what he called 'tropicalism' in Peru contributed to the spread of VD and therefore the solution to this problem lay at least in part in racial purity.

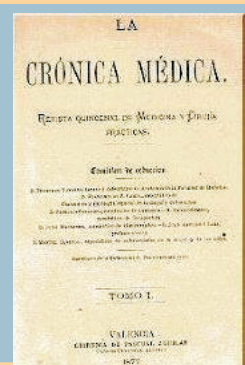
Marroquín insisted that understanding these social, biological and psychological factors that predisposed indigenous women to prostitute themselves was essential in order to understand the incidence of VD among "this race". He suggested that the indigenous denied the sexual nature of VD and instead blamed VD infection on the cold or a fall. As a consequence, he noted, they rarely cleaned their genitals after sex and thus "heightened considerably the risk of contagion". He lamented similarly the fact that the indigenous gave little importance to VD and did nothing to seek treatment or that when they did seek and obtain treatment they believed themselves cured as soon as the initial lesions healed, and finally, that Indians typically viewed VD as a stigma and would not reveal their condition to anyone.

If Gamio focused on racial hybridity to explain the incidence of VD in Peru, others focused more directly on the country's indigenous population in ways that similarly revealed a highly racialised understanding of both VD and of Peru itself. In his 1942 book titled *The Sexual Life of the Peruvian Indian*, Víctor L. Villavicencio pointed to the high incidence of VD among the indigenous as recorded by the authorities in charge of Peru's military conscription system. However, in a manner that evoked ideas of Indians as noble and innocent savages corrupted by the outside world, Villavicencio suggested that the source of VD contagion was external to the indigenous: "(I)t is likely that the vehicles of these diseases in the indigenous community are the Indians who have lived in towns [marked by] modern civilisation and the men who while not Indian themselves rape the Indian women".²¹ The trope of Indian innocence became the trope of Indian ignorance in Dr. T. Gutierrez Molero's 1943 call for an antivenereal campaign in the Peruvian 'sierra' (highlands). According to Molero "the aboriginal element, the Indian" had no understanding of the most basic principles of hygiene and was therefore "naturally because of this state of ignorance" easy prey to all sorts of diseases and most

particularly venereal diseases. As attested by military doctors who dealt with Indian conscripts regularly, Molero argued, when the Indians left the lands in which they lived “in total abandonment” and arrived in the military training camps, “they are more or less like children who know nothing of the dangers [of VD] or [of means of] prevention”.²² For Molero, a campaign to educate the indigenous about the effects of venereal disease was necessary because in addition to undermining their health, VD also created social problems that were a threat to both the ‘Family’ and the ‘State’. He suggested the use of two vehicles to educate the indigenous: Brigades of Indian education (Brigadas de culturización indígena) and rural schoolteachers. Together these educators of Indians would contribute to incorporating “that great mass which constitutes the dead weight of Peruvianness” as a “useful element in the life of the Nation”.²³

For José Marroquín, writing the same year as Gutierrez Molero, the indigenous in Peru were in the grips of a venereal epidemic that reflected not so much their innocence or their ignorance but rather their sexual culture and more generally indigenous culture itself. Marroquín rejected the widely held belief that indigenous women did not prostitute themselves. He noted that the fact that few indigenous women were found in the country’s brothels meant little. Most indigenous prostitutes were in fact circumspect prostitutes who worked ostensibly as cooks, washerwomen and domestic servants but who in fact practised prostitution in the homes where they were employed. He rejected José Antonio Encinas’s (a Peruvian educationalist) argument that most indigenous women were forced into prostitution after being sexually initiated by their employers. Marroquín argued that this was true only of a minority. Most indigenous women had undergone sexual initiation in the context of indigenous cultural practices which he listed as frequent festivities, alcoholism, *servinacuy* (a Quechua word which denotes cohabiting before marriage) and *pongaje* (performing labour services for one’s landlord) and as a consequence of incest.²⁴

La Cronica Medica



Marroquín went on to argue that indigenous women were predisposed to prostitution for biological, psychological and social reasons. He noted that indigenous women were naturally sexually lascivious and attributed this to endocrine ovary hypofunction, reflected in the “typical anthropological characteristics of their genitalia: infantile vulva, lack of pubic hair, undefined feminine physiognomic traits, masculine behaviour in domestic activities”.²⁵ These characteristics, Marroquín argued, were also found in prostitutes. Indigenous women were also drawn to prostitution for psychological reasons; specifically because they lacked sexual ethics. He argued that the indigenous more generally had no moral concept of sexual acts. Women typically engaged in sexual relations with several men before marriage while men were not averse to marrying women who already had children since they were considered useful as additional field hands. Marroquín went even further to argue that another psychological trait that contributed to indigenous prostitution was the inherent utilitarianism of the Indians. He

suggested that because the Indians were typically poor and had little property, they tended to refuse to do anyone any favours or to undertake any sort of unremunerated services. By contrast they were willing to do anything for money, including engaging in sexual acts for very little money indeed.

Among the social factors that contributed to indigenous prostitution, Marroquín listed early sexual initiation, little or no vigilance of such practices by relatives, the limited or zero value given to chastity, the tendency to live communally in very small dwellings. Besides, the near naked state in which indigenous people supposedly lived, the regular use of alcohol by both children and adults, the pathologies that they inherited as a consequence of alcohol abuse, coca chewing and venereal diseases, the ‘quality’ of marriage, by which he meant that the indigenous often did not marry but cohabited, the *colono* system, i.e. the fact that indigenous families who rented or were given land on a hacienda were subject to the landowner’s every whim, the ragged geology of the highlands, which, he argued, “favour secrecy in sexual practices”, and finally the “quality of their festivities” because he noted, “in addition to drinking too much, they sleep wherever they fall in the most complete unconsciousness and promiscuity”.²⁶

Marroquín insisted that understanding these social, biological and psychological factors that predisposed indigenous women to prostitute themselves was essential in order to understand the incidence of VD among “this race”. He suggested that the indigenous denied the sexual nature of VD and instead blamed VD infection on the cold or a fall. As a consequence, he noted, they rarely cleaned their genitals after sex and thus “heightened considerably the risk of contagion”. He lamented similarly the fact that the indigenous gave little importance to VD and did nothing to seek treatment or that when they did seek and obtain treatment they believed themselves cured as soon as the initial lesions healed, and finally, that Indians typically viewed VD as a stigma and would not reveal their condition to anyone.

Conclusion

The extraordinary texts reveal the ways in which VD served to channel the racial anxieties of Peru’s medical community in the first half of the twentieth century. It is important to stress that these were not fringe ideas. These texts were published for the most part in Peru’s flagship medical journal, *La Crónica Médica*. Pasquel’s 1911 dissertation was reproduced verbatim in the pages of this illustrious publication. These, then, were acceptable and widely accepted views, all the more remarkable for the fact that although the focus of racial anxiety changed over time from the Chinese to the indigenous, reflecting a broader demographic process in Peruvian society (namely the beginnings of mass rural to urban migration in the 1940s which profoundly transformed the character of Peru’s capital and of Peru itself), the way in which VD was racialised was essentially the same in 1910 as in 1940. For these medical doctors, if VD was a threat to the social and national body it was because VD was both a reflection of and, in turn, a contributor to, racial inferiority. The Chinese and the indigenous were susceptible to VD because they were racially and culturally inferior (they were dirty, promiscuous, uncivilised). In turn, VD contagion contributed directly to the racial and cultural inferiority of the Chinese and the indigenous since it led to the degeneration of their races. More worrying still, VD made the Chinese and the indigenous a threat not only to themselves but to the Peruvian nation itself. It followed that the medical campaigns to combat VD were not merely understood as a way to reduce the spread of gonorrhoea and syphilis. They were primarily a means to overcome the perceived racial backwardness of the country.

- 1 This paper draws on research funded by the Wellcome Trust and the British Academy.
- 2 See, among others, Allan M. Brandt, *No Magic Bullet: A Social History of Venereal Disease in the United States since 1880*, Oxford University Press, New York, 1985; Donna Guy, *Sex & Danger in Buenos Aires: Prostitution, Family, and Nation in Argentina*, University of Nebraska Press, Lincoln, 1991; Megan Vaughan, *Curing their Ills: Colonial Power and African Illness*, Stanford University Press, Stanford, 1991; Sergio Carrara, *Tributo a Venus: A Luta Contra a Sífilis No Brasil, Da Passagem Do Seculo Aos Anos 40*, Editora Fiocruz, Rio de Janeiro, 1996; Katherine Bliss, *Compromised Positions: Prostitution, Public Health, and Gender Politics in Revolutionary Mexico City*, Pennsylvania State University Press, University Park, Pennsylvania, 2001; Laura Briggs, *Reproducing Empire: Race, Sex, Science, and U.S. Imperialism in Puerto Rico*, University of California Press, Berkeley, 2002; Philippa Levine, *Prostitution, Race, and Politics: Policing Venereal Disease in the British Empire*, Routledge, New York, 2003.
- 3 Roger Davidson and Lesley A. Hall, "Introduction", in Roger Davidson and Lesley A. Hall (eds.), *Sex, Sin and Suffering: Venereal Disease and European Society since 1870*, Routledge, London, 2001, p. 4.
- 4 Laura Engelstein, "Morality and the Wooden Spoon: Russian Doctors View Syphilis, Social Class, and Sexual Behavior, 1890-1905", *Representations*, 14, 1986, pp. 169-208.
- 5 Karen Jochelson, *The Colour of Disease: Syphilis and Racism in South Africa, 1880-1950*, Palgrave, Houndmills, 2001, p. 6.
- 6 On "radesyge" in Norway, see Anne Kveim Lie, "Origin Stories and the Norwegian Radesyge", *Social History of Medicine*, 20, 3, 2007, pp. 563-579.
- 7 *Monitor Médico*, Año IV, 82, 15 October 1888, p. 150.
- 8 Ibid.
- 9 Ibid., p. 151.
- 10 Ibid.
- 11 "Memoria anual del Médico sanitario municipal del Cuartel 3", in *Memoria de la Municipalidad de Lima 1901*, Librería e Imprenta Gil, Lima, 1901, p. xxxi.
- 12 Alfonso Pasquel, "La sífilis en Lima", Thesis, Medicine Faculty, Lima, 1911. Reproduced in *La Crónica Médica*, Año XXVIII, 550, 30 November 1911, pp. 316-324, and later issues, including *La Crónica Médica*, Año XXIX, 557, May 1912, pp. 409-423.
- 13 Ibid., p. 412.
- 14 Ibid., p. 419.
- 15 Ibid.
- 16 Ibid.
- 17 *Crónica Médica*, 60, 961, July 1943, pp. 212-217.
- 18 Ibid., pp. 213.
- 19 Ibid.
- 20 The literature on biopolitics is too vast to cite here. For the original formulation, however, see Michel Foucault, *Society Must be Defended: Lectures at the Collège de France, 1975-76*, Penguin, London, 2004; and Michel Foucault, *Security, Territory, Population: Lectures at the Collège de France 1977-1978*, Picador, London, 2009.
- 21 Víctor L. Villavicencio, *La Vida Sexual del Indígena Peruano*, Taller Gráfico de P Barrantes, Lima, 1942, p. 79.
- 22 *Crónica Médica*, 60 962 August 1943, pp. 209-211 (210).
- 23 Ibid.

- 24** *Crónica Médica*, 60 966 December 1943, pp. 339-345. See also *Crónica Médica*, 62 980 February 1945, pp. 51-57.
- 25** *Ibid.*, p. 342.
- 26** *Ibid.*, p. 344.

Picture Source:

1. <http://img141.imageshack.us/img141/7223/06frontis2.jpg>
2. <http://www.imeval.org/img/cronica.jpg>

Narrating AIDS in Cuba



History of Medicine in the Global South

Narrating AIDS in Cuba

This paper explores some of the key dimensions of the history of AIDS in Cuba, through a review of recent debates about Cuban AIDS policy, and an analysis of an oral history interview with a young Cuban man living with AIDS. Focussing on a series of issues in one interview, the article aims to identify a number of key themes in the history of Cuban AIDS, and to highlight the challenges of writing such a history. These challenges are inextricably linked to the intensely ideological debates surrounding the history– and future– of the Cuban Revolution.



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AIDS in Cuba

Although healthcare has often been hailed as one of the greatest successes of the Cuban Revolution, the revolutionary government's approach to the AIDS crisis has been highly controversial. Following the first confirmed cases of HIV infection on the island in 1986, the Cuban government instigated a policy of compulsory HIV testing; those who tested positive were confined to compulsory sanatoria, and people who developed AIDS were hospitalised.¹ Compulsory quarantine was lifted in 1993, but in the contemporary period testing is still compulsory among certain groups,² and people who test positive for HIV must spend some time in a sanatorium in order to receive instruction on how to live with the virus and to protect others from exposure. The Cuban government also keeps an anonymous database with information on HIV-positive patients, including names of past sexual partners.

Critics have condemned the quarantine system in CUBA's AIDS policy, arguing that it 1) Undermines sexual education initiatives by creating the impression that HIV infection is not an issue for the general population; 2) Reflects the authoritarian nature of the Cuban political system, which restricts public debate about policy, and therefore minimises the participation of dissident voices, and the formation of grassroots organisations; and 3) Restricts the freedom of individuals and groups of people with HIV and AIDS, and increases the stigma associated with them.

In terms of the aim of minimising levels of HIV infection and deaths from AIDS, there is evidence that quarantine has been successful: Cuba has the lowest HIV infection rate in the Caribbean, and death rates from AIDS-related illnesses are around seven per cent.³ But critics have also condemned the quarantine system, arguing that it 1) Undermines sexual education initiatives by creating the impression that HIV infection is not an issue for the general population; 2) Reflects the authoritarian nature of the Cuban political system, which restricts public debate about policy, and therefore minimises the participation of dissident voices, and the formation of grassroot organisations; and 3) Restricts the freedom of individuals and groups of people with HIV and AIDS, and increases the stigma associated with them.

In his important study of sexual education, sexuality, gender and AIDS in Cuba, Marvin Leiner highlights the contradiction between Cuba's generally outstanding achievements in education, on one hand, and the revolutionary government's failure during the early years of the epidemic to develop a coherent AIDS education policy, on the other.⁴ In the late 1970s, Cuba initiated a sexual education programme in state schools, following models and textbooks inspired by East German sexologists. AIDS education, however, required a much wider campaign directed at the general population. Without this, throughout the 1980s and 1990s the quarantine system may have given the impression that most Cubans were 'safe' from HIV infection. By the late 1990s, this situation began to change, with the founding of the National Centre for the Prevention of STDs and HIV.⁵ In addition, since the early twenty first century, the National Centre for Sex Education (CENESEX) has conducted numerous studies into HIV and AIDS,⁶ organised national education campaigns, participated in international AIDS conferences, and campaigned against the social stigmatisation of those groups most affected by AIDS, especially transgender people and men who have sex with men. The high profile of the director of CENESEX, Mariela Castro (daughter of President Raúl Castro) has contributed substantially to the publicity surrounding the changes in Cuba's approach to AIDS and sexual diversity.

It is important to remember, nevertheless, that both the National Centre for Prevention and CENESEX are government organisations. Although they facilitate the participation of non-governmental actors in AIDS education and activism, they are not initiatives founded or led by people with HIV and AIDS. As Leiner and some others have noted, the current system provides

little opportunity for those affected most by AIDS to participate in decision-making about their own care. “Those in Cuba who have questioned the quarantine policy,” wrote Leiner in the mid-1990s, “are labelled ‘enemies of the Revolution,’ thus effectively excluding the possibility of public advocacy [for quarantine patients]...”⁷ This example demonstrates how certain topics are constructed as ‘taboo’ inside Cuba not through direct censorship,⁸ but via the construction of dissident voices as ‘counterrevolutionary’, a technique that dates back to the early years of the Revolution. One of the earliest groups to be targeted by this technique was men identified as homosexual.

Mariela Castro



AIDS policy and homophobia

Unlike in North America and Europe, where AIDS was quickly labelled in the media as a ‘gay disease’, in Cuba men who have sex with men were not singled out for testing in the early stages of the epidemic. Instead, efforts to limit the spread of HIV focused on Cubans who had travelled abroad or had had contact with foreigners, most notably troops returning from the war in Angola.⁹ This has led some to claim that the quarantine policy has not discriminated against homosexual and bisexual men.¹⁰ But this argument fails to take into account both the wider sets of discourses that worked to associate AIDS with male homosexuality in the popular Cuban imagination, and the legacy of institutionalised homophobia in the early years of the Revolution, particularly during the 1960s and 1970s.¹¹

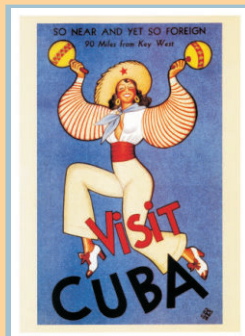
Even if AIDS was not initially associated with men who have sex with men inside Cuba, the Cuban media quickly picked up on outside reports of a ‘gay disease’, helping to create the impression that heterosexuals were safe from infection.¹² Since the media is state-controlled in Cuba, its reporting of AIDS essentially reflected the views of revolutionary officials. As Shawn Smallman writes, the construction of AIDS as a disease of gay American men was common throughout Latin America during the 1980s.¹³ Fidel Castro, in one of his famously long speeches, actually blamed the US for bringing AIDS to Latin America.¹⁴

This kind of language echoed over three decades of revolutionary rhetoric, which had constructed the United States as an imperial aggressor that had corrupted Cuban innocence before 1959 by exporting vice and decadence to the island. This rhetorical association of the US with moral deprivation, and with gay promiscuity in particular, was reinforced during the AIDS crisis when the first death from AIDS-related causes to be reported by the Cuban press was that of a theatre designer who had supposedly become infected during a trip to New York.¹⁵ Of course, Cuba was hardly unique in the 1980s in having a media that associated AIDS with homosexuality. But whereas the aggressively homophobic tone of media representations of the AIDS epidemic in countries such as the United States and the United Kingdom led to a militant reaction among gay activists, decades of state-sanctioned homophobia, as well as the prohibition against self-organisation, prevented the formation of a collective or community response among

Cuban men who had sex with men.¹⁶

The pattern of HIV infection in Cuba has differed from that in the rest of Latin America and many other parts of the world.¹⁷ By the mid to late 1990s, the majority of new HIV cases diagnosed in Cuba were men who have sex with men.¹⁸ Consequently, by the early years of the twenty-first century, the majority of the residents of Cuba's largest AIDS sanatorium— Los Cocos, in Santiago de las Vegas outside Havana— were identified as homosexual and bisexual men in their twenties and thirties.¹⁹ A number of observers and sanatoria patients argue that quarantine continues to work against attempts to destigmatise people with AIDS, by making them more isolated and vulnerable to discrimination.²⁰ Although the link between quarantine and the stigmatisation of gay men may not be deliberate, it is reinforced by a series of historical resonances with previous homophobic policy in Cuba. During the early 1990s, when quarantine was still compulsory, Marvin Leiner outlined the double bind of AIDS patients in a regime that had historically defined some groups— including homosexual men — as 'anti-social' and 'counterrevolutionary':

Thus far, a handful of people have been deemed responsible enough to return [from the sanatoria] to society.... Being among these requires approval by a group of psychologists, medical personnel, and social workers who consider epidemiological records, psychiatric data, relations with family members, and the person's behavior while at the sanatorium (sic)... But, what is 'responsible' or 'trustworthy'? This is an Orwellian/Catch-22 nightmare. If you're a homosexual resident in a sanatorium (sic) and put on makeup or are considered 'effeminate,' is this 'irresponsible'?²¹



Homophobia Cuba

There are echoes here of the memoir of Cuban dissident Reinaldo Arenas, who described having to prove that he was a 'real homosexual' by parading in front of a group of police officers and psychologists before leaving the country in 1980.²² This episode underscores the extent to which, during the first two decades of the Cuban Revolution, homosexuality was treated as a security problem as well as a disease. It is worth remembering that until the end of the 1980s, the AIDS sanatoria were run by the Cuban Ministry of Defence.²³ As Smallman writes, "While these facilities with their small cabanas and manicured lawns appeared attractive, they initially had guards, gates, and in some cases fences topped by barbed wire."²⁴ This description is eerily reminiscent of the notorious UMAP (Military Units for the Aid of Production) of the mid 1960s, forced labour camps where men designated as homosexual were sent, along with other supposedly anti-social groups, for 'rehabilitation' by the Cuban army.

It would be simplistic to argue that AIDS policy in Cuba is designed explicitly to punish and control male homosexuality. Moreover, policy toward homosexuals, as well as AIDS patients generally, has changed in Cuba over the past several decades. But the example of the sanatoria suggests that the stigmatisation of homosexual men in particular has not disappeared entirely from state policy, notwithstanding official claims that early homophobia has been ‘rectified’.²⁵

Narrating AIDS

Paralleling the relatively late development of a cohesive AIDS education policy, public representations of AIDS in Cuba have emerged relatively recently. The most widely recognised Cuban AIDS narrative is the memoir of Arenas *Before Night Falls*, a stinging indictment of revolutionary homophobia. But since Arenas left Cuba in 1980, his writing bears witness to the AIDS epidemic in the United States, not inside Cuba.²⁶ On the island, the most public representations of AIDS have been in the form of television programmes and films, both with an explicitly pedagogical dimension. The filmmaker Belkis Vega has made a number of documentary and fictional films with AIDS themes.²⁷ More significant in terms of audience, in 2006 Cuban television drew international attention when one of its enormously popular soap operas, *The Dark Side of the Moon*, featured an HIV-positive bisexual man.²⁸ But while there is increased visibility of fictionalised representations of people with AIDS, public narratives from people living with the syndrome are rare, which is what makes Miguel’s interview particularly valuable.

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Miguel’s story²⁹

The interview with Miguel was conducted at the end of 2006, as part of the ‘Memories of the Cuban Revolution’ oral history project.³⁰ Miguel was born in Havana in 1972 to what he describes as a poor and humble family. The interviewer describes him as white,³¹ and he has four siblings. His father left the family when Miguel was a child, and Miguel was raised largely by his grandmother, with whom he was living at the time of the interview. He was diagnosed as HIV positive on his thirtieth birthday, in 2002. Although much of the interview focuses on Miguel’s experience of living with AIDS, it opens and closes with stories of police persecution of gay men.

Well, I’ll start by telling you that before gays were not seen as they are now. For example, in the old days if they saw you with makeup, if they saw you with a bit of makeup, with your eyebrows plucked, it wasn’t well received. Back then. Now, let’s say, they don’t do it directly, but there is mistreatment just the same. For that very reason we don’t have a place (to go). We don’t have anything. So the police don’t treat us as people, they treat us as homosexuals. So they send you to the station where they charge you.

Miguel’s use of the word ‘gay’ probably reflects his age, as someone whose adult life has been conditioned by the increase in tourism to Cuba since the 1990s, including Western gay male visitors. But in spite of his youth, Miguel is knowledgeable about the history of homophobic prejudice in Cuba, possibly recounted to him by older friends (as is the case with

another young gay interviewee). Miguel's perception of what has changed for gay men is actually the opposite of 'official' versions of history. According to Miguel, gay men are no longer poorly treated by society generally, but they *are* still constant targets of police harassment, arrest and, sometimes, violence. His opening words are followed by a pair of anecdotes about being arrested while out socialising with friends on the streets of Havana. These tales are very similar to those recounted by other self-identified male homosexual



Reinaldo Arenas

Miguel's stories demonstrate an understanding of the wider politics that lie behind police harassment of gay men. He and his friends are charged with 'laying siege to tourists'. In other words, although there is evidence of homophobia in the police treatment of Miguel and his friends (he complains that they call him *maricón*— 'poof' or 'fag', for example), the legal excuse for the arrest is the general ban on Cubans frequenting tourist areas, a prohibition designed in part to curb hustling. But although in theory any Cuban can be subject to arrest for being caught in the company of tourists, gay men are particularly likely to be targeted because, as Miguel puts it, given the lack of 'places' for gay men to gather, public spaces are their main space for socialising.³² Moreover, Miguel recognises that there is a more sinister threat behind the arrests: the police always have recourse to the 'danger' law, which targets people who pose a threat to public decency. Historically, the *ley de peligrosidad* has been used to control homosexual men in public places.

Following on from these stories of police harassment, the interviewer asked Miguel:
In your personal life, do you have a fixed job?

No. I have AIDS. I have emphysema and that prevents me from working because I have a lung that doesn't function, thanks to an operation I had here in this country, in X hospital.

In this statement a chain of related factors— AIDS, unemployment, poor health and poor healthcare— emerge, which will constitute the main topics of Miguel's interview. Miguel's story of his diagnosis with HIV and later development of AIDS goes through a series of dramatic and tragic episodes: the announcement of his HIV status on his birthday, for which he accuses the doctors who visited him at home with the news of a 'lack of tact'; his development of emphysema due, apparently, to the inadequate antibiotics given to him after a previous operation; and his generally disastrous experiences of the Cuban healthcare system, including deteriorating and filthy buildings (some of the descriptions of which are gothic in their detail), incompetent doctors, and a lack of medicine.

Although Miguel's stories contain elements found in recent reports of problems in Cuban hospitals,³³ I am less interested in proving whether his claims are factually accurate than in considering how they relate to his story of survival as a gay AIDS patient in Cuba. Faced with a potentially fatal illness and a repeated fear of 'drowning' in the night (as a result of his

failed lung), Miguel's life is saved, in his account, by an 'act of God' and a group of gay male nurses. A fluke fall in the bath clears his lung and the nurses manage to get medication not available in the hospital.

The religious tone of Miguel's tale may reflect a Catholic upbringing, with its emphasis on mystery and miracle— a set of beliefs that coexist, if awkwardly, with the discourse of rational materialism in Cuban socialism. Metaphorically, the gay male nurses in this tale play the role of angels. But their actions also demonstrate, as Miguel himself says, the solidarity among gay men in Cuba in the face of ongoing discrimination. Additionally, the nurses form part of a booming underground economy in which everything— from medication to houses to sexual services— can be bought illegally, at a price. In fact, Miguel's later tales of surviving AIDS abound with stories of buying medication in the street. Furthermore, like most Cubans, Miguel has become adept at making his small monthly salary and food ration stretch. "We have to become magicians", he says, in a wonderful description of the creative ways in which Cubans get by in the chaotic dual economy. But if Miguel's story demonstrates the trickster side of living with AIDS, it also paints more sinister scenarios: people with AIDS haunting tourist areas to hustle and beg; and male sex workers continuing to sell services to tourists after they test positive for HIV. In a classic vicious circle, Miguel blames what he says in an unofficial rise in HIV transmission on the fact that people have to earn a living any way they can.

It is impossible to verify these claims, and there is a moral tone to this last argument that ironically echoes the Cuban government's condemnation of sex workers as decadent and selfish.³⁴ In contrast, Miguel presents himself as someone responsible, both for his own physical and emotional health, and for that of others. Having AIDS has had a profound impact on Miguel's relationship with his family, as well as his sexual relationships. He was slow to reveal his HIV status to his family, because he did not want to hurt them. "I don't have to give them the details", he says, "because I don't want to make anyone sad". But his reluctance may also be related to the memory of their negative reaction when he told them, years before, that he was gay. His deteriorating health makes it more difficult to hide his status, and one of his sisters eventually confronts him directly— after watching an episode of the famous soap opera *The Dark Side of the Moon*.

Miguel also takes on the role of mentor and teacher in his interview. He wants to ensure his siblings know how to protect themselves from AIDS, by using condoms. When asked if he has a partner, he replies:

No, that has a big influence on relationships. Shall I tell you the truth? If I found a relationship I'd want someone who wasn't healthy, someone who was sick. Which is a contradiction at the same time, because it's not caring for one person, but caring for two. But, well, I wouldn't want to deceive anyone. I always have condoms on me, when I don't I try to avoid it altogether, even though I have to deny myself sex.

Miguel goes on to say that there are other things that make it difficult for him to have a relationship: The fact that he lives with his grandmother and cannot rent a place of his own— a reflection of Cuba's acute housing shortage³⁵— and the fact that although his family love and accept him, they have more difficulty seeing him 'with someone'.

Metaphorically, the gay male nurses in this tale play the role of angels. But their actions also demonstrate, as Miguel himself says, the solidarity among gay men in Cuba in the face of ongoing discrimination. Additionally, the nurses form part of a booming underground economy in which everything— from medication to houses to sexual services— can be bought illegally, at a price.

There is an element of self-sacrifice in Miguel's narrative, of putting the well-being of others ahead of his own. In a further ironic twist, given his harsh criticism of the Cuban

healthcare system, Miguel takes on the role of the good revolutionary— a contemporary version of the ‘new man’ celebrated by Che Guevara in the 1960s. Like the religious tone of his stories of recovery in hospital, this may be a legacy of Miguel’s childhood in the 1970s and 1980s, when Cuban school children were— as they still are today— taught the basic values of egalitarianism and solidarity, and encouraged to ‘be like Che’.

By taking on the responsibility of teaching his siblings about safer sex, and setting a good example by always carrying condoms, Miguel also plays the role of AIDS educator. His commitment to this kind of popular pedagogy both echoes the historical value placed on education— including voluntary teaching— under the Revolution, and serves to highlight what he perceives as the inadequacies in AIDS education, including inside the sanatoria, which he calls:

Horrible, the most unpleasant thing in the world. I didn’t want to go in, but well, later I became aware— it’s called the course on learning how to live with HIV.... There was little information for me, they gave the course to get paid, because there wasn’t much information. They didn’t provide any books, they didn’t provide any anecdotes.... They don’t get to the depth of what one’s living.... Shall I tell you the truth? If I’ve learnt about this it’s because I’ve read books about it, because I’ve arranged them with my friends, the nurses. But lots of people don’t get that!... Much of what I’ve studied about the illness that in some way or another can help us psychologically. Things like that I try to teach to people who don’t live with HIV. That’s why I accept any question, so that tomorrow they don’t fall into the same. It’s a mistake, well, so they don’t get infected. Most of all they inform themselves so they can help other people sociologically and they can do it. Because living with my illness isn’t easy, it’s waking up everyday without knowing what awaits you tomorrow.

Although this commitment to popular education is on some level reminiscent of the mass literacy campaigns in Cuba in the early 1960s, its do-it-yourself pedagogy perhaps has more in common with the popular health movements of second-wave feminism, or with the Gay Men’s Health Crisis. Such initiatives arose not from the state, but out of distrust in the ability traditional professional medicine to address the health needs of women and gay men, as well as a reaction against the shortcomings and prejudices of state sexual education programmes. As Leiner notes, such movements are virtually impossible in Cuba, because they come into conflict with the restrictions on extra-state organising.

An important element in Miguel’s model of popular education is the emphasis on psychological as well as physical health. The words ‘depressed’ and ‘stressed’ come up frequently in the interview. At several moments he describes his experiences of AIDS treatment as ‘depressing’. At one point he stops his story for a minute, saying “I’m getting stressed and I have to loosen up!” Finally, or rather, towards the beginning of the interview, after recounting his stories of police persecution, the interviewer asks:

And in your own case, how do you feel personally when the police bother you because they feel like it?

Very, very, very bad. Very depressed. It’s very stressful.

It is impossible to construct a history of AIDS in Cuba on one short interview analysis. But what this interview allows us to do— and what oral history brings to history more generally— is to trace the connections between different dimensions of recent history that are frequently told separately. Miguel’s brief narration of his life demonstrates that the history of HIV and AIDS treatment in Cuba can only be understood in relation to many other aspects of the country’s history over the past fifty years: Healthcare, education, the economy (including the informal market), housing, tourism, sex work, family structures, sexuality (and, I would add race, gender relations and social class), as well as the history of institutionalised homophobia.

Moreover, by listening to Miguel's story we perceive one of the fundamental contradictions of contemporary Cuban history: that the generation which is most likely to be critical of the Revolution in the early twenty-first century has in many cases drawn upon revolutionary teachings from their childhoods in the 1970s and 1980s— solidarity, equality and collective wellbeing— in order to find alternative survival strategies in an increasingly crisis-ridden society.

- 1 This section is based on Marvin Leiner, *Sexual Politics in Cuba: Machismo, Homosexuality and AIDS*, Westview Press, Boulder, Colorado, 1994, pp. 117-57; Anne-christine D'Adesky, *Moving Mountains: The Race to Treat Global AIDS*, Verso, London and New York, 2006, particularly "Cuba Fights AIDS its Own Way", pp. 70-92; and Tim Anderson, "HIV/AIDS treatment in Cuba: A rights-based analysis", *Health and Human Rights in Practice*, 11, 1, 2009, <http://www.hhrjournal.org/index.php/hhr/article/view/138/219>, accessed 30 January 2010.
- 2 Byron L. Barksdale, "The success story of HIV and AIDS control in Cuba", available on <http://www.prairiefirenewspaper.com/2009/02/success-story-of-hiv-and-aids-control-in-cuba>, accessed 30 January 2010.
- 3 Barksdale, "The success story".
- 4 Leiner, *Sexual Politics*, pp. 123-4.
- 5 Shawn C. Smallman, *The AIDS Pandemic in Latin America*, University of North Carolina Press, Chapel Hill, 2007, pp. 57-8.
- 6 Rossana de la Guardia Delgado and Ida González Nuñez, "Información del diagnóstico de VIH/SIDA a menores de 15 años" *Sexología y sociedad*, 10, 26, December 2004, pp. 52-57; Dixie Edith Trinquete Díaz, "Adolescentes y VIH/SIDA: Quién dijo que todo está perdido?" *Sexología y sociedad*, 11, 27, April 2005, pp. 4-7.
- 7 Leiner, *Sexual Politics*, p. 2.
- 8 Some critics have claimed that the Cuban government concealed exact numbers of HIV and AIDS cases during the early years of the epidemic, though Smallman argues that by the early 1990s the statistics were verifiable. Smallman, *The AIDS Pandemic*, pp. 45-6.
- 9 For a brief overview of the testing policy, see Leiner, *Sexual Politics*, p. 122. Cuban soldiers participated in the Angolan war between 1975 and 1989.
- 10 Anderson, "HIV/AIDS treatment in Cuba", pp. 95-6.
- 11 There is a large literature on homosexuality and homophobia under the Cuban Revolution. See in particular, Ian Lumsden, *Machos, Maricones, and Gays: Cuba and Homosexuality*, Latin American Bureau, London, 1996. For a detailed analysis of explanations for homophobic policy in revolutionary Cuba, see my manuscript in progress, *Sexual Politics: Passion and Politics in Socialist Cuba*.
- 12 Leiner, *Sexual Politics*, p. 136.
- 13 Smallman, *The AIDS Pandemic*, p. 12.
- 14 Fidel Castro, speech, September 1988. Cited in Smallman, *The AIDS Pandemic*, pp. 12-13 and Leiner, *Sexual Politics*, p. 131.
- 15 Lumsden, *Machos, Maricones, and Gays*, p. 165.
- 16 Leiner, *Sexual Politics*, p. 147.
- 17 Smallman, *The AIDS Pandemic*, p. 35.
- 18 D'Adesky, "Cuba Fights AIDS"; Anderson, "HIV/AIDS treatment in Cuba".
- 19 D'Adesky, "Cuba Fights AIDS", p. 72.
- 20 Ibid., pp. 78-79.
- 21 Leiner, *Sexual Politics*, pp. 120-21.

- 22 Reinaldo Arenas, *Before Night Falls*, Serpent's Tale, London, 2001, p. 281.
- 23 Smallman, *The AIDS Pandemic*, p. 42.
- 24 Ibid., pp. 41-2.
- 25 'Rectification' is the term given to the process, during the mid 1980s, whereby previous revolutionary errors were acknowledged and corrected. The 1993 release of the film *Strawberry and Chocolate* (dir. Tomás Gutiérrez Alea) is frequently cited as evidence of a tacit official acknowledgement that early revolutionary homophobia was a mistake.
- 26 Similarly, exiled Cuban writer Severo Sarduy's AIDS memoir, which was published posthumously as *Pajaros de la playa* (2001), recounts his illness in France.
- 27 *Viviendo al límites* (2004); *Donde no habita el olvido* (2005); *El futuro es mi sueño* (2006).
- 28 Paquita Armas Fonesca, "Un rostro revelado", <http://www.caimanbarbudo.cu/caiman333/paginas/novela33.htm>, accessed 30 January 2010.
- 29 Miguel is a pseudonym.
- 30 The project is directed by Professor Elizabeth Dore and co-hosted by the University of Southampton (UK) and CENESEX in Havana. Between 2004 and 2008 a group of twelve Cuban and British researchers, including myself, interviewed some one hundred Cubans in and around Havana and Santiago de Cuba. The interview analysed here was conducted by a Cuban research assistant.
- 31 Because racial identities in Cuba are typically based on skin colour rather than ancestry, Miguel may or may not be categorised as 'white' outside Cuba, and indeed may himself have another racial identity.
- 32 Of course, the police may also associate gay men with hustling. Another group particularly vulnerable to police harassment in tourist areas are black and *mulata* Cuban women, who are typically stereotyped as sex workers. See Alejandro de la Fuente, *A Nation for All: Race, Inequality and Politics in Twentieth-Century Cuba*, University of North Carolina Press, Chapel Hill 2001, pp. 326-7.
- 33 As Whiteford and Branch wrote, "shortages of medical supplies abound". They add however, that "there is no shortage of medical personnel to provide care". Linda M. Whiteford and Laurence G. Branch, *Primary Healthcare in Cuba: The Other Revolution*, Rowman and Littlefield Publishers, Plymouth, 2008, p. 2.
- 34 As Noelle Strout writes, the view that sex workers are people who do not want to do hard work, and that the government should criminalise *jineterismo* is shared by many Cubans as well, including some who identify themselves as homosexual. Noelle Stout, "Feminists, Queers and Critics: Debating the Cuban Sex Trade", *Journal of Latin American Studies*, 40, 2008, pp. 721-42.
- 35 For an analysis of the impact of the housing shortage on Cubans in same-sex relationships, see Carrie Hamilton, "Sexual Politics and Socialist Housing: Building Homes in Revolutionary Cuba", *Gender & History*, 21, 3, pp. 608-27.

Picture Source:

1. <http://www.cubaencuentro.com/var/cubaencuentro.com/storage/images/cuba/noticias/mariela-castro-que-no-se-privie-a-la-gente-de-su-derecho-de-salir-del-pais-84198/mariela-castro/693874-1-esl-ES/mariela-castro.jpg>

2. <http://cubaa.files.wordpress.com/2007/12/visit-cuba-print-c100197302.jpeg>

3. [Http://vueltaporeluniverso.files.wordpress.com/2009/10/reinaldoarenas.jpg](http://vueltaporeluniverso.files.wordpress.com/2009/10/reinaldoarenas.jpg)



Tsunami and the Construction of Disabled Southern Body



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Tsunami and the Construction of Disabled Southern Body

This paper explores a Southern disabled standpoint as a theoretical and strategic approach to examine disability. In situating disabled people in the South within dominant Northern notions of development and medicine, this paper focuses on the 2004 December Tsunami. Our aim is to highlight how the separation of an episodic natural disaster from the ongoing social disaster of war and poverty, is based on a specific approach to understanding the Southern body within Northern medicine. By explaining how able-bodied masculine notions of the body are constructed within imperialist and ethno-nationalist projects, this paper suggests a deeper understanding of disability in the South for informed social transformation.



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Introduction

I do agree that the Tsunami was a wonderful opportunity to show not just the US government, but the heart of the American people, and I think it has paid great dividends for us. (sic.)

Condoleezza Rice, Senate Confirmation Hearing, January 2005.

This paper explores a Southern disabled standpoint as a theoretical and strategic approach to examine disability. Positioned in a specific subordinated space within the global capitalist economy under the hegemony of the U.S., this Southern standpoint is a critical materialist one. In order for Southern disabled people to transform their subordination and exploitation, this paper argues for a politics of impairment that combines economic redistribution with cultural elaboration of solidarity, justice and care. By situating the analysis of 'disability' in terms of disabled people in the South, the aim is to encourage a deeper understanding of disability, particularly in terms of social policy and social mobilisation.

To undertake this task, we will use the 2004 December Tsunami to illustrate not only a particular disability discourse, but also the location of the Southern disabled body within North-South power relations. While some may argue, such a construction confuses ecology with typology, we will demonstrate that the Tsunami is a metaphor for Southern bodies and ecologies that are typologised within a specific power hierarchy. In brief, the representations of both the Tsunami and the disabled body are considered 'freaks of nature',¹ which coincides with the spread of global markets and imperial violence, reconfiguring the human body.

In terms of theory, this paper elaborates the materialist social model proposed by C. Barnes and G. Mercer, which merges disability with radically transforming capitalism². In highlighting how disability in the South and the Southern body are represented in times of 'natural' disasters, we argue that the Eurocentric masculine imperialist project situates Southern disabled people as a sub-species of nature. The complicity of ethno-nationalist strategies within the South with able-bodied masculinity has particular implications for Southern women and girls with disabilities. By juxtaposing the Tsunami with the disabled body, the aim is to further extend the politics of impairment.

Northern depictions of the Tsunami and its aftermath reproduced a popular Northern imagining— that disasters live in the South. From mudslides in Central America, earthquakes in Pakistan to famine (along with violence) in Dafur, disasters seem to lurk in the South. For the dominant Northern imaginings, the 'disastrous South' exists as a permanent condition. Even the devastation of hurricane Katrina in New Orleans illustrated the media and state responses to marginalised southern black bodies in the U.S. During the Tsunami the Northern bodies of tourists were more important than local Southern bodies. This representation of the Southern black body is firmly anchored in flattening their histories and their culturally textured daily lives.

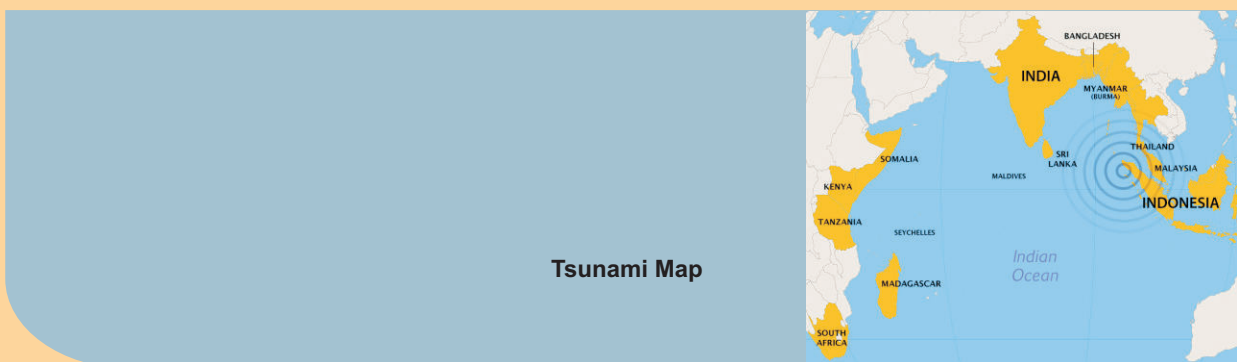
The 2004 December Tsunami

The majority of bodies affected by the December 2004 Tsunami belonged to women and children. According to the World Bank, the tsunami killed 129,775 people in Indonesia with 39,786 missing and 192,055 displaced.³ In Sri Lanka, 35,322 people were killed, over 5,000 went missing, and 516,150 were internally displaced. In Aceh, the World Bank estimated that total funds needed were 5.8 billion USD, where 8.9 billion USD has been pledged.⁴ In Sri Lanka, the need was 2.2 billion USD with 2.8 billion USD in pledges.⁵ By late 2005, almost twelve months after the disaster, the conditions of poverty and war have remained mostly unchanged. While the Tsunami's human toll was overwhelming, the lagged and inadequate

their geo-political landscapes and redescribed in a Eurocentric masculine worldview. In the case of the Tsunami, this reinforced dominant notions of the Tropics.

These Northern representations of the 2004 Tsunami illustrate the ways in which western medicine draws specific geographic boundaries around ‘warm climates’, pathologising the tropics. Referred to as ‘Tropicality’, this discourse creates a sense of otherness to “the tropical environment, the difference of plant and animal life, and the climate and topography, the indigenous societies and their cultures and the distinctive nature of disease”.¹³ In re-enacting ‘Tropicality’, the Northern Tsunami discourse rationalises the hegemony of western medicine by re-affirming the inherent dangers to life and health in the equatorial regions and the need for western medical intervention. The Tsunami, in this Eurocentric hierarchy of being, was something that only lives in Southern geographical spaces, away from the safe and controllable ecologies of the North. Just like the Southern disabled and impaired body, the Tsunami is a part of nature that cannot be stopped, but something that can be prepared for, so that it can be controlled and managed by superior Northern technocratic expertise.

With ecological events and Southern bodies located close to nature, this representation of black bodies as a ‘vulnerable’ sub-species form the basis for legitimising imperialist projects under U.S. hegemony. The Tsunami was a “wonderful opportunity” for the North, according to Condoleezza Rice (as quoted above), to re-establish its superiority and enlightened imperial benevolence. The response of Northern governments masked the more brutal coercive dimensions of political and military coordination of the global spread of markets. As Jeremy Seabrook so eloquently elucidated, “Western governments, which can disburse so lavishly in the art of war, offer a few million as it were exceptional largesse”.¹⁴ In effect, the incapacities of local state forms to provide social protection expose the contradictions of neo-liberal strategies promoting ‘self-regulating free markets’ as ‘development’. Not only does this cater to Northern Transnational Corporations (TNCs), but it also fosters ethno-nationalist militarised counter-movements based on able-bodied patriarchy. In turn, a key ‘blind-spot’ of the Northern imaginings in representing the black Southern body, battered by disaster was the ‘nature’ of the North-South relationship.



Disability in the South

Although most of the world’s disabled population lives in the South, there is higher “incidence of reported impairment” in the North.¹⁵ According to the World Bank, there are 600 million disabled people globally, of whom 400 million live in the South.¹⁶ As opposed to the North, life expectancies are shorter in the South, there are limited health and support services, and some conditions (such as dyslexia) are not considered as impairments.¹⁷ There are a range of preventable impairments that are caused by lack of access to basic amenities such as safe water, sanitation, electricity, and health services. The limits of state capacities to regulate and extend

response of the rich Northern nation-states and international development agencies also reveal the ongoing human costs of market-driven 'development'.



Tsunami Death

Disaster, Disability and Southern Bodies in Northern Discourse

Northern depictions of the Tsunami and its aftermath reproduced a popular Northern imagining—that disasters live in the South. From mudslides in Central America, earthquakes in Pakistan to famine (along with violence) in Dafur, disasters seem to lurk in the South. For the dominant Northern imaginings, the 'disastrous South' exists as a permanent condition. Even the devastation of hurricane Katrina in New Orleans illustrated the media and state responses to marginalised southern black bodies in the U.S. During the Tsunami the Northern bodies of tourists were more important than local Southern bodies. This representation of the Southern black body is firmly anchored in flattening their histories and their culturally textured daily lives. Thus, socially entrenched dominant power relations of class, gender, ethnicity and disability are made invisible, along with a multitude of contentious collective struggles for recognition, representation and redistribution.

Representations of natural disaster and Southern bodies are intertwined with Western anthropocentric perspectives of science, which deploy a 'natural' hierarchy of species and the notion of a sub-species.⁶ In this hierarchy of species, humans are situated as superior to nature but certain human beings are closer to nature than others. The idea of the sub-species conveys how human biology can be measured and layered into a 'hierarchy of being'.⁷ At the pinnacle of this hierarchy are white western men whereas women, black and impaired bodies are located closer to nature. The superiority of whiteness is in both physicality and intelligence, where knowledge about self and others is reduced to a value-neutral positivist discourse of 'science' and 'rationality'.⁸

The proximity to nature of the colonised and the disabled represents a specific sub-species, along with others. Distinguished by the lack of rational and reasoned thought, and the propensity to indulge in the moment of being "resulting in self-loss", these lesser beings are never capable of fully realising oneself.⁹ Living within a world of unconscious acts driven by irrationality, emotion and non-intelligence, the "unreason" of the sub-species "prevents us from determining or understanding nature itself".¹⁰ Nature and those parts of the sub-species are thus overwhelmed by irrational acts, with great desires to nurture or destroy everything in its path, without thought or understanding. The impaired and disabled represent this 'sub-status of irrationality', which reproduce those 'sub-human freaks' of nature.¹¹

This notion of the sub-species was illustrated by the separation of the Tsunami and nature from the human. This accompanies the positioning of whiteness, the 'human', as disconnected from, and superior to brownness, the 'natural'.¹² By separating nature from humanity and represented as 'otherness', cultural and social histories are also disconnected from

social provisions depict how the promotion of international competitiveness has enhanced the power of private insurance and drug (pharmaceutical) companies in driving disability policy.¹⁸

Disability in the South is situated in a subordinated status within the global disability marketplace. The market for rehabilitation goods and services related to disability is dominated by the interests of TNCs, particularly insurance and drug (pharmaceutical) companies. Major drug and medical supply companies are expanding into the South promoting deregulation and privatisation of the health sectors. The current North-South tensions over intellectual property issues and prices of essential medicines, particularly HIV/AIDS drugs, highlight the role of TNCs as well as the WTO in shaping the global disability marketplace. While subordinating the needs of disabled people, cultural practices and the national sovereignty of the South, the profit driven disability market is also influenced by the recurrent crises of capitalist economies. Not only is the South particularly effected by the changes in the global marketplace, there is a generalised amplification of risk through food sources, genetic modification and accumulated drug resistance as well as from the environment, climate change, unknown hazards in the workplace and unregulated proliferation of biological, chemical and nuclear weapons.¹⁹ This relationship between the global disability market and the militarisation of the globe is of particular interest for disability in the South.

The outbreak and maintenance of civil wars in the South relate to nation-state strategies which are interdependent with imperialist efforts to expand and protect markets. The post-second world war global system under U.S. hegemony has promoted an international system of “imperialism by invitation”.²⁰ While inviting ‘self-governing’ states to participate in the international trading regime, the new hegemony is sustained by “political and military coordination with other independent governments”.²¹ The global trade in military weapons plays a key role in maintaining market-friendly governments while militarising conflicts in the South.

Disability in the South is intertwined with civil wars, where both state and insurrectionary groups use maiming rather than killing to undermine resistance and socialise fear.²² The global military industrial networks, including international arms trade, dominated by Northern countries and often invisible in World Bank ‘development’ discourse, illustrates the coercive dimension of market-led ‘development’. Northern countries accounted for about 75 per cent of world military spending in 2004 but contained only sixteen per cent of the world population. The U.S. accounts for nearly half of world military spending. In 2004, the military spending of the U.S. amounted to nearly 400 billion USD, compared with 6.4 billion USD in Indonesia and 19.1 billion USD in India.²³ The GDP of Sri Lanka in 2004 was around 21 billion USD, while military spending was nearly 560 million USD. The role of the Indonesian military in protecting the interests of Exxon Mobil, one of the major U.S. petroleum TNCs, illustrates how national politics of resource-rich Southern countries are interconnected with geopolitics of imperialism. Moreover, the productive, docile, bodies that the World Bank and nation-state strategies promote for ‘development’ are also Southern bodies faced with human right abuses.²⁴

Global market forces shape and are reshaped by underlying social structures and cultures of disability, primarily in the terrain of national politics. Disability in the South is positioned within a neo-liberal ‘development’ discourse, which prioritises international competitiveness through trade liberalisation where under market-driven politics the state promotes the interests of capital through privatisation and deregulation.²⁵ Consequently, government regulation or social provisioning is seen not only favouring sectional interests and encouraging inefficiencies, but also state bureaucracies are seen as inherently acting to maximise their own interests. Thus, privatisation under public-private partnerships is promoted, blurring the public-private

distinction. As for disability policy, the retraction of state social provisioning and the privatisation of health services have amplified household care labour, particularly women's care work.

Under market-driven politics, disabled people are located in the periphery of labour markets, where able-bodied labour constitutes the valorised core. In order to attract international investors, the active promotion of a skilled and docile labour force also means creating a labour market which restricts basic worker rights, such as freedom of association and collective bargaining. In effect, more people are disabled by the lack of decent work, safety and health regulations and poverty-level wages. However, there are other recruits from a pool of underemployed and unemployed workers, in urban slums and impoverished rural communities. This marginalisation also feeds into the proliferation of ethno-nationalist counter-movements, in hope of gaining recognition and redistribution.

Authoritarian ethno-nationalism, nature and able-bodied patriarchy

While strengthening conditions for global capital to invest and operate, the state's attempts to gain legitimacy is increasingly based on patriarchal ethno-nationalist strategies. In contrast to earlier closed economy projects, this nationalist development discourse is committed to market-driven politics. While there are different versions of this nationalist project, they are grounded in able-bodied patriarchal constructions of nationhood where the nation is represented as masculine reason. This depiction of the nation-state as masculine reason excludes women from the 'social' and ascribes them to 'nature'. In effect, women are engaged in reproducing the nation, biologically, culturally as well as symbolically.²⁶ By casting the Tsunami as an irrational act of nature, humanity is masculinised while nature is feminised.

The Southern disabled standpoint suggested in this paper emerges from a cultural critique within the South itself. The dominant representation of nations in terms of able-bodied ethno-nationalist patriarchy is at the heart of this critique. The feminisation of both nation and nature by able-bodied ethno-nationalist patriarchy deploys notions of 'tradition' and 'motherland' with strategic intent. With women narrowed to their maternal and nurturing function, this representation of women as biological reproducers of the nation is central for the domestication of women while restricting their status as citizens.

The masculinity implied in patriarchal ethno-nationalist strategies is an able-bodied masculinity. The emphasis on ability relates to how culturally mediated economic activities, discipline, control, subjugate and reproduce bodies as well as embodiment. The body is central to the self as a project as well as social status.²⁷ In effect, the body is shaped by both cultural and material practices. The dominant forms of masculinity articulated in nationalist projects are an able-bodied masculinity, which is based on evading the shared frailty of human beings and the vulnerability as social beings.²⁸ While the body is "inescapable in the construction of masculinity", the bodily performance that valorises ability is also related to the de-valuation of the disabled body.²⁹ The able-bodied masculinity of ethno-nationalist projects overlap with fascist tendencies which Connell describes as a "naked assertion of male supremacy".³⁰ The fascist image of masculinity combines disparate dispositions of "unrestrained violence of frontline soldiers", rationality (bureaucratic institutionalisation of violence) and ironically, irrationality too (thinking with 'the blood', the triumph of the 'will' etc.).³¹ In turn, elements of dominance as well as technical expertise are core features of able-bodied masculinity that subordinate disabled bodies and women.

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nature by able-bodied ethno-nationalist patriarchy deploys notions of ‘tradition’ and ‘motherland’ with strategic intent. With women narrowed to their maternal and nurturing function, this representation of women as biological reproducers of the nation is central for the domestication of women while restricting their status as citizens. While relegating women and disabled bodies into the private sphere of the household,³² the patriarchal ethno-nationalist projects maintain a masculinised public sphere. Just as a woman’s status as citizen within the public domain is conditioned by the active role of the state constructing relations in the private domain, of marriage and the family,³³ the citizenship status of disabled bodies are also shaped by similar interventions.³⁴ This is even more so for women with disabilities, who are regarded as unfit to reproduce the nation.³⁵ In responding to the Tsunami, the ‘humanity’ of the imperial state(s) merged with able-bodied patriarchal state strategies to separate and evade the inhumanity of poverty and war that continue to reproduce disabling structures and cultures in the South. By contesting the privileged/hegemonic position of the Northern notions of development, disability, and disasters, the Southern disabled standpoint is aimed at deepening politics of impairment.

Conclusion

The delineation of disability as ‘natural’ and disability caused by war and poverty as ‘cultural’ is a specific value-laden framework. The separation of natural and human disasters obscures their shared properties and how culture and history mediates in defining them. While the tsunami had a natural dimension as an ecological event, the consequences of that event were shaped by pre-existing culturally mediated material practices. By the time the Tsunami arrived in Sri Lanka and Aceh, the Southern body had already endured extensive destruction and violence under ethno-nationalist state strategies and Northern notions of ‘development’. Despite the billion-dollar pledges the response of rich Northern nation states, impairments caused by war and poverty endure. Thus, the Tsunami can be deployed as a material metaphor to examine the Southern disabled body, where those ‘freaks of nature’ provide ‘opportunities’ for Northern scientific technocratic expertise and imperial benevolence.

For politics of impairment, disabling barriers generated by war and poverty in the South, are inseparable from market-driven ‘development’ and global military networks. With the majority of people with disabilities located in the South or the ‘majority world’, the ongoing articulation of North-South relations is significant for elaborating a critical Southern standpoint on able-bodied masculinity.

- 1 We borrow this term from Rosemarie Garland Thomson’s work on modernity and the cultural spectacle of the ‘other’ body within the global north. See Thomson (ed.), *Freakery: Cultural spectacles of the extraordinary body*, New York University Press, New York, 1996.
- 2 C. Barnes and G. Mercer, “Understanding impairment and disability: Towards an international perspective”, in Barnes and Mercer (eds.), *The Social Model of Disability: Europe and the Majority World*, The Disability Press, Leeds, 2005, pp. 1-16.
- 3 World Bank, *World Bank, partners call for global cooperation to “unlock” opportunities for millions of disabled people*, 2005, available on <http://www.worldbank.org/disability>, retrieved 26.01.2006.
- 4 World Bank, *Indonesia key statistics– Tsunami Recovery in Indonesia: Aceh and Nias*, 2006, available on http://www.aceh-eye.org/data_files/english_format/aceh_disaster/aceh-eye_disaster_donor/tsunami_donor_agencies_worldbank/tsunami_donor_agencies_worldban

- k/tsunami_donor_wbank_others_2005_12_01.pdf, retrieved 07.03.2006.
- 5 World Bank, *Sri Lanka key statistics– Tsunami Recovery in Sri Lanka*, 2006, available on <http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/EXTTTSUNAMI>, retrieved on 07.03.2006.
 - 6 K. Soper, *What is nature? Culture, politics and the non-human*, Blackwell, Oxford, 1995.
 - 7 D. Perry and R. Whiteside, *Women, gender and disability: Historical and contemporary intersections of “otherness”*, 1995, p. 5, available on <http://www.academyanalyticarts.org/perrywhitside.htm>, retrieved on 23.09.2005.
 - 8 Ibid. See also C. Kaplan, “Afterword: Liberalism, Feminism and Defect”, in H. Deutsch and F. Nussbaum (eds.), *“Defects”: Engendering the modern body*, University of Michigan Press, Ann Arbor, Michigan, 2000, pp. 303-318.
 - 9 M. Ryle and K. Soper, *To relish the sublime? Culture and self-realisation in postmodern times*, Verso, London, 2002, p. 26.
 - 10 J. Reed, “Monstrous knowledge: Representing the national body in eighteenth-century Ireland”, in Deutsch and Nussbaum (eds.), *“Defects”: Engendering the modern body*, pp. 154-176.
 - 11 Perry and Whiteside, *Women, gender and disability*.
 - 12 V. Prashad, “Churning of the ocean: The Tsunami and the third world”, *Polity*, 2, 2005, pp. 31-33.
 - 13 G. Bankoff, “Rendering the world unsafe: ‘Vulnerability’ as Western discourse”, *Disasters*, 25, 2001, pp. 19-35.
 - 14 Jeremy Seabrook, “In death, imperialism lives on”, *The Guardian*, 31.12.2004, available on <http://www.guardian.co.uk/world/2004/dec/31/tsunami2004.pressandpublishing>, retrieved on 18.12.2005.
 - 15 Barnes and Mercer, “Understanding impairment and disability”.
 - 16 World Bank, *World Bank, partners call for global cooperation to “unlock” opportunities for millions of disabled people*, 2005, available on <http://www.worldbank.org/disability>, retrieved 26.01.2006.
 - 17 Barnes and Mercer, “Understanding impairment and disability”.
 - 18 G. Albrecht and M. Bury, “The Political Economy of the Disability Marketplace”, in G. Albrecht, K. Seelman and M. Bury (eds.), *Handbook of Disability Studies*, Sage, Thousand Oaks, CA, 2001, pp. 585-609.
 - 19 Ibid.
 - 20 L. Panitch, and S. Gindin, “Global capitalism and American Empire”, *Socialist Register*, 2003 available on <http://www.monthlyreview.org/sr2004.htm#contribs>, retrieved 17.01.2006.
 - 21 Ibid.
 - 22 Barnes and Mercer, “Understanding impairment and disability”.
 - 23 Global Issues, “Arms Trade: Global Military Spending”, 2006, available on <http://www.globalissues.org/Geopolitics/ArmsTrade/Spending.asp>, retrieved 18.02.2006.
 - 24 Amnesty International, *Just earth! Indonesia– Oil and mining projects threaten communities in Aceh and Papua*, 2001, available on <http://www.amnestyusa.org/justearth/indonesia.html>, retrieved 20.03.2006.
 - 25 C. Leys, *Market-driven Politics: Neo-liberal Democracy and the Public Interest*, Verso, London, 2001.
 - 26 N. Yuval-Davis, *Gender and Nation*, Sage, London, 1997.
 - 27 B. Turner, “Disability and the sociology of the body”, in Albrecht, Seelman and Bury (eds.), *Handbook of Disability Studies*, pp. 252-266.

28 Ibid.

29 R. Connell, *Masculinities*, Allen and Unwin, St. Leonards, NSW, 1995, p. 56.

30 Ibid, p. 193.

31 Ibid.

32 V. Das and R. Addlakha, "Disability and domestic citizenship: Voice, gender and the making of the subject", *Public Culture*, 13, 2001, pp. 511-531; C. Mohanty, "'Under Western Eyes' revisited: Feminist solidarity through anticapitalist struggles", *Signs: Journal of Women in Culture and Society*, 28, 2002, pp. 499-535.

33 Yuval-Davis, *Gender and Nation*.

34 H. Meekosha and L. Dowse, "Enabling citizenship: Gender, disability and citizenship in Australia", *Feminist Review*, 57, 1997, pp. 49-72.

35 Das and Addlakha, "Disability and domestic citizenship".

Picture Source:

1. <http://www.tsunamis.com/tsunami-map.jpg>

2. <Http://blogs.reuters.com/wp-content/uploads/2007/03/Tsunami%20-%20Low%20Res.jpg>

Antidotes for Historical Dis-eases

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Projit Bihari Mukharji

Recent decades have witnessed a massive outpouring of scholarship on the History of Medicine [HoM] in general and South Asian HoM in particular. Much of the scholarship, with a few exceptions, has been produced in the United Kingdom. The high concentration of production in one particular geographic location has made the scholarship singularly susceptible to the homogenising forces generated by specific academic webs of interest. These webs of interest, materialised in the form of interlocked networks of institutional [departmental] cultures, funding programmes, selection criteria for journals, academic jobs, studentships and even mutual friendships between scholars, had fostered an understanding of HoM which was increasingly arcane. The discussions within this scholarship were increasingly self-referential and its professional practices increasingly divorced from the practice of History in general. Scholars and entire departments (including 'units' and 'centres') began self-identifying as specifically devoted to the study of HoM rather than History. In many ways HoM was on its way to becoming a separate discipline in its own right rather than a specialism within History. This is not to suggest that the HoM scholarship thus produced was critically impotent or somehow compromised. Far from it. Indeed the narrower field of vision encouraged greater acuity. However, at a time when besides the

Military, Medicine is the largest industrial complex that mediates 'global' society and culture, there is an unquestionable need to re-site medicine within larger force fields of power and domination. Two recent workshops have tried to mobilise for precisely such a re-siting.

Interestingly both workshops used navigational terminology to name themselves. The first of these was titled '*Situating* Subalternity in South Asian Medicine' while the latter was called '*Locating* the "Medical" in Histories of Medicine'. *Situating* and *locating*, of course, are both navigational terms. They designate positioning something within a broader field. The first workshop sought to locate the 'Subalternity' – variously understood as marginality, powerlessness, domination etc. – within 'South Asian Medicine', while the latter sought to situate 'Medicine' itself within a broader framework that included the shrinking territory of the non-Medical.

The first of the two workshops mentioned was held at the Centre for the Study of Developing Societies in New Delhi on 18-19 February 2010 and was co-organised by Helen Lambert and Shail Mayaram. In many ways it followed up on an earlier gathering organised by David Hardiman at Warwick University in 2009. Though the primary interest of the organisers was to re-introduce questions of power and domination – especially in its absolute manifestations rather than its relativistic forms – into the study of health and healing, it soon became clear that another question haunted the workshop. As participants delved into the histories of healers, patients and forms of healing farthest away from elite medicine, it became clear that what precisely was 'medical' was also becoming blurred and the question that haunted all was what precisely was the 'history of medicine' and whether there was anything to be gained by studying it as a separate discipline? David Hardiman spoke of the medicine of colonial missionaries and how this often worked within a much older notion of religious medicine practised by Bhakti saints and carried forward by later day saints such as the Sai Baba of Shirdi. Shail Mayaram spoke of a shrine at Hussein Tekri in Rajasthan, where a woman heals while being possessed. Molly Kaushal spoke of the role of trances in healing amongst the Gaddis of Himachal Pradesh. Priyadarshini Vijaiashri explored the ritual cosmology of disease in the Sakta tradition. Neshat Quaiser's paper touched upon evil spirits or *balas* and their role in Islamicate etiologies of disease. My own paper dwelt upon the rich and living tradition of using *mantras* to cure. In all of these papers, the world of religion, spirits and ghosts could be seen to be intricately bound up and entangled with the seemingly somatic world of the body. Magic and medicine seemed to be much harder to disentangle in these histories than is often assumed. *Mantras* for instance claimed to cure perfectly 'somatic' complaints such as cholera or malaria. Diseases were as easily understood as having been caused by germs as by evil spirits or sin or interrupted social rhythms. This however was not the only way in which the insularities of the histories of medicine came undone. Burton Cleetus explored how caste reform and migration patterns influenced the re-definition of Ayurveda in late colonial and post-colonial Kerala. Quaiser described how commerce bifurcated the world of Islamicate medicine in Delhi into high Unani and *bazari* [of the market] medicine. Laurent Pordié explored how re-definitions of Tibetan [Amchi] medicine within a strongly Buddhist framework affected a family of Muslim Amchi. Madhulika Banerjee gave a participants' account of how Rajasthani 'wise-men' or Gunis – whose medical knowledge was being progressively marginalised by state-support for more institutionalised forms of medicine – are successfully politically organising themselves. Helen Lambert similarly showed how massaging techniques which were much more broadly available in the Rajasthani country-side, especially amongst wrestlers, had been organised as a specialised 'healing' tradition amongst *har-vaidyas*.

Each of these papers demonstrated either how the world of medicine was always structured by processes which had apparently nothing to do with medicine, or, how knowledge

and practice that was previously not identified as being specifically ‘medical’ and formed part of a society’s shared ‘wisdom’— at particular moments in time— crystallised into a specialist ‘healing’ corpus. Harish Naraindas’ paper attempted to provide a larger framework within which to locate the ambiguities of the ‘medical’. He argued that indigenous therapeutic traditions of South Asia had always had ‘esoteric’ and ‘exoteric’ dimensions, which resulted in the intricate mixture of ritual, spiritual, religious and somatic values. ‘Modernisation’ drives however, have progressively tried to suppress and extinguish the esoteric dimensions of cure. He further suggested that this drive was not wholly successful as even while using biomedical cures, many South Asian patients continue to supplement the biomedical therapeutics by prayers, rituals etc.

Besides the ambiguities of the ‘medical’, another question that engaged participants was how to get beyond ethnography? What instigated this question no doubt was the largely interdisciplinary nature of the workshop which brought together an almost equal number of historians and anthropologists with a sprinkling of activists and sociologists. It was clear from the many rich and detailed studies presented that certain broad patterns of belief, action and the operation of power in therapeutic situations could be discerned in studies situated in very distinct geographic contexts. Yet, given our contemporary [and I would risk adding, well-founded] mistrust of structuralist homilies and generalisations about ‘Indic civilisations’, there seemed to be a debilitating crisis which was forcing studies to remain firmly entrenched within a narrowly ‘localised’ ethnographic frame of knowledge even when the larger patterns could be clearly observed. On the one hand such reticence to generalise interrupted the possibility of drawing out broader conclusions about the nature of domination and subordination within histories of cure, while on the other hand— and this is more troubling— it risked naturalising the ‘local’ as the only possible unit of investigation. For a group of scholars whose purpose avowedly was to practice a more engaged form of HoM, especially within an emerging global context of the Medical Industrial Complex, such fragmentation of the academic field of vision was particularly disconcerting. Optimistically however, the very organisation of a workshop such as this, and the promise to publish a volume based upon it, would encourage further comparisons and hopefully suggest ways of transcending localised ethnographies.

The second workshop was organised by Rohan Deb Roy and Guy Attewell at the Wellcome Centre for the History of Medicine at the University College, London on 30 April and 1 May 2010. The workshop’s ambition was to disturb the stability of the ‘Medical’ as a category. Long misrepresented as a bastion of HoM orthodoxy, the workshop once again brought to fore the diversity and richness of research conducted at the Wellcome Centre in UCL. The overlaps between this workshop and the former, though largely unplanned, were significant. One of the organisers, Guy Attewell, was closely involved with organisation of the Subaltern Workshops at Warwick and Delhi, at least two of the participants, Bodhisattva Kar and myself, had attended both the Warwick and Delhi workshops and another participant, David Arnold, had participated at the Warwick workshop which was a precursor of sorts for the gathering at Delhi.

Just as ‘locating the medical’ had become an unintended subtext of the Delhi workshop, the ‘delineations of power’ came to haunt the London conference. While overtly concerned with finding out what was specifically ‘medical’ and whether there was any such specificity, a good many papers also touched upon the way power operated in certain ‘medical’ contexts. Clare Anderson’s paper on the massive archive built up by J.P. Walker, a medical administrator in colonial India, explored why Walker’s medical records contained almost no mention of the considerable time he spent in India as a colonial administrator known amongst other things for having hanged over eighty convicts in single afternoon in the Andamans. Rohan Deb Roy explored how professional protocols, influential authors, dialogue with other emerging, non-

medical disciplines such as Geology and colonial networks allowed the construction of the category 'Malaria' as a stable and homogenised medical term. John Mathew in an exceptionally picturesque presentation explored how and why, 'Natural History' was marginalised by the colonial networks and context of British India. He discussed how those who had had the utmost exposure to the cutting edge of Victorian Natural History chose instead to devote themselves to Medicine. Stephen Legg's richly theorised paper delved into how the dynamics of controlling prostitution in inter-war India operationalised very different praxes of power whose object at different times were the bodies of prostitutes or the spaces they inhabited. Durba Mitra's paper investigated how the emergent discursive practices of medical jurisprudence in the nineteenth century, inscribed the bodies of colonised women. Shinjini Das described how the 'family' became both a trope and a locus through which homeopathy in colonial Bengal was materialised within a distinctly patriarchic matrix of power. Similarly, Jonathon Saha's paper on colonial Burma [present day Myanmar] explored how the colonial state was engendered through its everyday breaches, in the form of regular medical malpractices, as a masculine state. Each of these papers, besides troubling any fixed notion of the 'medical', also presented the myriad different forms of power— colonial, medico-juridical, biopolitical, sovereign, patriarchal, state etc. — which intersected and overdetermined medical transactions. Besides these, another group of papers focussed more specifically on the nature of medical power. Shrimoy Roychaudhuri investigated how different genres of writing about poisons, served to define the nature of medical power. Guy Attewell pondered over how Unani medicine transcreated therapeutic objects through an exploration of the many lives of *paan* [beetel leaf] within and without the 'medical' and how this changed over time. My own paper looked at medicines dealing with hair to explore the ways in which medical power in Bengali Ayurvedic texts had repeatedly redefined its operational possibilities. David Arnold's paper explored how late-colonial Indian industrialists re-deployed the language and power of medicine in the context of everyday technologies such as type-writers, soaps, bicycles etc. Each of these papers showed how medical power— what it does, what it is etc. — has been repeatedly transformed in its scope and nature in the course of its histories. Bodhisattva Kar's rich and ambitious paper attempted to bring the various threads together and provide a much-needed theoretical structure for the discussions. He argued that not only the 'medical' but also notions such as the 'social' and the 'everyday' which had come up in the course of the workshop needed to be problematised. He called for a species of critical engagement which would look at what Latour has described as concrete 'programmes of action' and not take anything for granted.

Kar's comments gesture towards the other concerns that repeatedly surfaced amongst the participants of the workshop. On the one hand many papers, such as Deb Roy's, Attewell's and in a slightly different aspect, Mathew's, Roychaudhuri's and my own paper, could be said to be very broadly 'constructionist'. They speak of the 'construction' of pathological categories, therapeutic objects, professional disciplines, medicinal values and human bodies. Superficially, these resemble the 'social constructionist' literature which since the mid-1960s has animated a significant portion of the academia. Ian Hacking has argued that the starting point of a 'social constructionist' approach is to challenge the seeming 'inevitability' of something. He further identifies the range of politics— from the ironic to the revolutionary— which inform these challenges. Much of this applies to the papers presented at the workshop. However, it would be wrong to classify these discussions as purely 'social constructionist'. Wary of the emerging critiques of the 'social' as a pre-formed category, most of the papers actually eschewed claiming that the objects of their study were *socially* constructed. Most of them focussed instead on networks though, once again eschewing more firmly Actor-Network-Theory based approaches, they also included forms of power in their 'constructionist' narratives. While most of these

papers were undoubtedly engaged in challenging the inevitability of terms associated with HoM, the dual focus on modes of power as well as network of actors suggest that they are probably best described simply as ‘constructionist’ rather than ‘social constructionist’.

A second issue highlighted by Kar and present in many of the papers, was the notion of the everyday. Saha spoke of the everyday state, Arnold spoke of everyday technologies, Attewell mentioned everyday commodities and Das described the everyday of the pharmaceutical business. The range of everyday in itself shows the fruitful new dimensions that this notion is opening up for critical enquiry, but Kar’s cautions too are cogent. An overemphasis on the everyday might reify the quotidian and obscure the truly singular from view.

Finally, a general dis-ease that emerged from both the workshops pertains to the plasticity of definitional categories. What is decisively ‘subaltern’ about this? Or, what exactly is ‘medical’ about this? Or indeed, what precisely is ‘colonial’ about that?— were questions which arose with unerring regularity at both workshops. These are no doubt pertinent questions. But their persistence and the inability to give satisfactory answers seems to suggest that a very different approach to such questions might be needed. Some authors, addressing themselves particularly to the last of the three questions, have recently suggested that the persistence of the question might prove its own redundancy. But should we take this to mean that we stop asking these questions altogether? As Ann Laura Stoler has suggested in response to claims to pin down what exactly is ‘colonial’, “Empires are not brittle. It is our conceptions of empire that become so when we force them into an either/or conversation. Empires have thrived on... conceptual pluralities; critiques of empire, it would seem, do not”. Others like Giles Deleuze and Felix Guattari have suggested that ‘anexactitude’ viz. deliberate and not accidental inexactness, at times might be more critically productive than an insistence on hermetically sealed definitional categories. Fuzzy impressionist paintings or pen-n-ink caricatures after all, frequently enable greater insights and space for critical comment than naive and doggedly realist detailings of a subject. What both of these workshops have done, I believe, is to encourage precisely this kind of scholarship which gets beyond the facile and often impotent conundrums of definitional minutiae and hinted towards the emergence of a new, more political, critical scholarship on medicine which is in constant dialogue with other critical practitioners of History. They have both tried to break the stultifying mould that has recently threatened to turn history of medicine into a site for the industrial production of remarkably similar and arcane works. To what extent both or either of these workshops succeed in breaking that mould is for the future to see, but they undoubtedly have the potential of becoming important starting points for newer, fresher and more critically engaged histories of medicine in South Asia: Histories which instead of trying to find an universally valid definition of the “subaltern”, the “colonial” or the “medical”, will explore the dynamic re-negotiations between the universal, the particular and the singular deployments of these terms.

The Bhopal Judgment

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Atig Ghosh

No doubt but ye are the people, and wisdom shall die with you¹

The last few days have been like a bombing run, one explosive event after another: The deliberate derailment of the *Jnaneswari Express* in West Midnapore (West Bengal), the defeat of the ruling Left Front in the municipal polls of the same state, and then the long and eagerly-awaited judgment on the Bhopal Gas Tragedy. At least for those of us who, in spite of ourselves, still, somewhat feverishly, remain interested in the everyday goings-on of the nation-state, it has been a breathless run.

The *Jnaneswari* tragedy was grimly surprising.

The Left Front rout was anticipated.

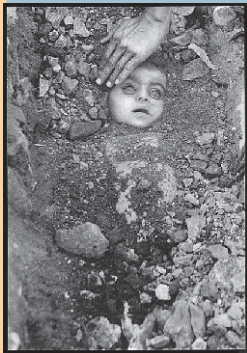
And the Bhopal judgment has been a shocking surprise for many who had reposed unshakeable trust in the just dispensation of the Indian judiciary or at least had, with that cynic confidence of pessimists, thought that the magnitude of the Bhopal tragedy would arm-twist the otherwise unpredictable judiciary to be just and unforgiving. A just judgment they had sought. The phrase ‘just judgment’ is not tautological; for that is what ‘we’ had expected and what ‘we’ got in stead is an ‘unjust judgment’. The popular surprise— and uproar— stems from this denial of hope. Yet, one wonders whether the *judgment* could ever have been *just* for the victims of the Bhopal gas-leak. But, first, the narrative needs to be put on track before we turn to observations.

The Bhopal disaster or Bhopal Gas Tragedy is the world's worst industrial catastrophe and occurred on the night of 2-3 December 1984 at the Union Carbide India Limited (UCIL) pesticide plant in Bhopal, Madhya Pradesh, India. At that time, UCIL was the Indian subsidiary of the U.S. company Union Carbide Corporation (UCC), which is now a subsidiary of Dow Chemical Company. Around midnight on the fateful day, there was a leak of methyl isocyanate (MIC) gas and other toxins from the plant, resulting in the exposure of over 500,000 people. Estimates vary on the death toll. The official immediate death toll was 2,259 and the government of Madhya Pradesh has confirmed a total of 3,787 deaths related to the gas release. Other government agencies estimate 15,000 deaths. Non-governmental bodies estimate that 8,000 died within the first weeks and that another 8,000 have since died from long-term effects.

Some 25 years after the gas leak, 390 tonnes of toxic chemicals abandoned at the UCIL plant continue to leak and pollute the groundwater in the region and affect generations of Bhopal residents who depend on it.

Culled from http://en.wikipedia.org/wiki/Bhopal_gas_tragedy, accessed on 25.06.2010.

Let us not pretend and admit candidly that the enormity of lives lost leaves a deeper impress upon us than a solitary road accident. The gravity and extent of genocides, pogroms, mass murders, or grisly accidents shake our complacency and *compassion fatigue* more effectively. We secretly feel grateful for not having been victims of such colossal tragedies, for not having been *there and then*, so to speak. And then the guilty relief turns into moral outrage: We weep with the victims and decry, in maximal stridency, the unjust measures that the government invariably and historically seems to adopt. We click our tongues in despair, wag our incriminating fingers at the judicature and ultimately accept all of it as kismet: Such is reality, though *it shouldn't have been so*.



The Iconic Image of a Victim that Sent a Shiver Down Many a Spine

The broader social reaction to the judgment on the Bhopal Gas Tragedy has been quite similar. Only, the circumstances are a little different this time. When the killer Methyl isocyanate leaked from the Union Carbide India Ltd (UCIL) pesticide plant in Bhopal on the night of 2-3 December 1984 killing 15,274 people (official figures), I was three years old. It has taken 26 years since for the judgment to be announced. Meanwhile, some hundred-thousand people, according to the Amnesty International, continue to suffer 'chronic and debilitating illnesses' and thousands still drink polluted groundwater in the lake-city of Bhopal. This is the first *it-shouldn't-have-been-so*. Then the judgment itself, offering clemency on grounds of age and ailment to those responsible for the disaster, constitutes the second *it-shouldn't-have-been-so*. The seven Indian men, held guilty under Sections 304A (causing death by negligence), 336, 337, and 338 (gross negligence) of the Indian Penal Code, were sentenced to two years in jail (but bail for now) and Rs.101,000 in fines. The original charge had been culpable homicide that was changed under Supreme Court orders in 1996 to causing death by negligence. Indeed, as an activist declared: "The world's worst industrial disaster has been converted into something like a traffic accident". The people's verdict on the judgment too is out: It is thoroughly unjust.

And unjust it is. For those of us who have walked with the activists and victims of the Bhopal Gas Tragedy on the streets of the capital, sat with them in demonstrations, or generally

felt in solidarity with them from a distance, the pinched look of suffering about the faces of the victims seen upfront and broadcast through the national media remains an indelible memory. A footsore and wounded crowd it was which had for nearly three decades been pushed around the corridors of power while they clamoured for justice. Family members were lost and permanently maimed. The aftermath continues to scar the lives and bodies of successive generations. And finally when the judgment landed tamely on the offenders, the sense of outrage is justified. To the extent justice is commensurate revenge, one may speculate, any verdict would have fallen short: Imposing a verdict of life-sentence and higher, even astronomical, fines on a clutch of doddering old men could have hardly served to heal the wounds of the sufferers. I am not trying to be wilfully uncharitable. Let there be no doubt that if the people whose lives have been permanently disfigured wish for a sterner verdict, their wish should be unequivocally upheld. The denial of that wish is a crime.

Yet, one wonders why one must peg her/his hopes on the just dispensation of the legal machinery of the nation-state. What is it about democracy that holds us in permanent thralldom? It may be because of a general mood that has come to pervade us in recent times. In a Hollywood short-hand, it may be described as the *Erin Brockovich* mood. There's the individual law-abiding citizen and there's the big corporation— a supranational, multi-billion-dollar monstrosity wreaking havoc on environment and life and apparently unstoppable in its cataclysmic programme. Then the individual fights the big corporation through the law courts of the nation. The trial drags on seemingly interminably. The course of the trial is punctuated by moments of triumph and reversal for the individual with the big corporation haltingly conceding defeat by millimetres each time. In the end, the global Goliath capitulates to the force of Justice and coughs up a million or two in compensation to the democratic David and— *bingo!*— the hallowed rights of the most insignificant individual prevails.

All this does not lead simply to the nasty observation— which, by the way, is true— that a recompense of a few million dollars for an MNC with multi-billion-dollar turnover amounts to a pittance and that the public shame is not of much consequence either for such MNCs continue in their recklessness undaunted; if not a gas-leak in Bhopal, then an oil-spill in the Gulf of Mexico it shall be. Further, such sagas serve to dissociate the nation-state from the huggermugger of big corporations; for it is through the mediation of the nation-state and its august institutions that the culprit is taken to task. They mask, I am suggesting, the connivance of capital and country. Democracy is upheld as the political ethic that enables the most insignificant of entities to rally against behemoths and, more interestingly, win. Such instances, however few, provides us with hope in an age of great foreboding and fear for the uncertain future. The nation-state apparently entrenched in democratic practices would protect us, when need be, against the onslaught of global capital. In return, we are to legitimise it as the best and only choice for socio-political belonging.

What is most important about the Bhopal judgment is that it explodes this happy symbiosis. The imbrication of the nation-state and big corporation stands brutally exposed in the wake of the judgment. If we are to believe the judiciary, the top brass of the UCIL had decimated thousands of lives as if in a fit of absentmindedness. When gas victim Shahnawaz Khan, a lawyer, had sent a legal notice to J. Mukund, former works manager of the Union Carbide factory, some twenty months before the gas-leak saying that 50,000 odd people living around the factory may be exposed to poisonous emission, the latter had found such an anxiety 'unfounded' and 'baseless'. Vijay Gokhale, then UCIL managing director, was deeply pained when at a social gathering he was asked, "Are you Nathuram Godse or Vijay Gokhale?" *Poor thing!*

Warren Anderson, who was the chairman of the US-based Union Carbide Corporation at

the time of the Bhopal gas-leak, went scot-free and he went scot-free for a reason. Whether the Chief Minister of Madhya Pradesh at the time, Arjun Singh, was a beneficiary of Anderson and helped him flee Bhopal after the leak, or whether the minister had deep pockets and sticky fingers (which he surely had), is beside the point. Anderson's acquittal should be seen alongside two other acquittals. While UCIL has been fined a paltry Rs.501,000, Union Carbide (US) and Union Carbide Eastern (Hong Kong), like Anderson, went scot-free. This triple 'oversight' must be considered in conjunction with the eagerness of the Indian state to attract foreign investment, on the one hand, and the related fact of there being the nuclear liability bill in the anvil, on the other. The Civil Liability for Nuclear Damage Bill, 2010, was introduced in the last parliamentary session. The Bill, in its existing form, seeks to minimise the responsibility of foreign suppliers and investors in the event of a nuclear accident. A harsher judgment and punitive measures against Anderson, Union Carbide (US) and Union Carbide Eastern (Hong Kong) would surely have strengthened the critics of the Bill and would have made the intention behind the Bill look insincere. The government, in its future plans, will brook no such setback.

The point is this: For me, the historical importance of the Bhopal judgment inheres in the fact that the collusion of capital and nation-state stand starkly exposed. It is a moment when we should give up our civil-social pretensions that are mired in a stout faith in democracy and recognise the nation-state for what it is.

Then, the many investments in India of the Dow Chemicals (which has bought over the Union Carbide) had also to be protected. Reacting to the judgment, Dow Chemicals has shoved off all responsibility and plainly stated that neither it nor its officials are subject to the Indian court's jurisdiction. The defiant arrogance of the MNC may not have come as an entirely unexpected shock to the government. In anticipation, the judgment on Bhopal had already been tempered. If the Left Front has been a particularly vocal opponent of the nuclear liability bill, there's no way the Front can distance itself from the Dow Chemicals. The Chief Minister of Left Front-ruled West Bengal, Buddhadeb Bhattacharya, who is a leader of the Communist Party of India (Marxist), has recently declared himself to be 'a broker of all capitalists'. Now, he has a much-hyped pet project—the proposed chemical hub at Nayachar, an ecologically fragile zone located on the coast of the Bay of Bengal. And the Dow Chemicals has substantial involvement there. If Dow were to pull out, the project could be severely jeopardised. Indeed, then, the pie extends from the state capitals all the way to the Union capital. Any setbacks are quite intolerable for the future plans for any and all the governments, in the states *and* at the centre.

A Protest Against the Disaster and the Treatment



The point is this (and I am repeating): For me, the historical importance of the Bhopal judgment inheres in the fact that the collusion of capital and nation-state stand starkly exposed. It is a moment when we should give up our civil-social pretensions that are mired in a stout faith in democracy and recognise the nation-state for what it is. It's an obtuse point; yet we seem never to

get it. I am not suggesting the complete abandonment of legal procedure. We should not vacate any space of resistance whatever its worth may be. But, action through the institutions of the nation-state should necessarily be coupled with the recognition that the legitimacy and authority of the nation-state can never be effectively imperilled through the use of one or more of its organs. For that, we need to search for a different redoubt. Outside courtrooms, in public fora and popular dissemination, for example, the polemic could be pitched at the level of exposing the incorrigible iniquities of the nation (and its irredeemable) state. There are some, operative in parts of India, who are trying out other, more radical, alternatives as well.

No matter which form we choose, the talk of an ‘unjust judgment’ invariably takes away the sting from all forms of resistance and bogs us in the regular fantasy of democratic justice of the nation-state which then continues to stand divorced from multi-national corporations and as the legitimate custodian of individual rights and lives; for, an ‘unjust judgment’ already-always announces the possibility of ‘just judgments’. While it is foolhardy to reject whatever little concession the nation-state allows us now and then, we should at the same time understand that none of that would be forthcoming once the aspirations of the people are squarely pitted against the immediate design of the powers that be—the capitalist corporation and the nation-state. If such is the situation, surely, the former would not mind coughing up a few thousand dollars and the latter would not mind overlooking a few thousand deaths.

Let me conclude by voicing an apprehension. The *Erin Brockovich* mood, which reproduces and sustains our faith in democracy and the nation-state, may be described as a Foucauldian mood. There is no escape from the entrapment of the national and the enchantment of the democratic. Yet, the Bhopal judgment, as I have argued, seems to offer us an opportunity of disrupting this single-note symphony of the *national-democratic*. However, even as I make these hopeful noises, an apprehension gathers force. Perhaps, this charged opportunity would be lost as our civil-social disposition relaxes into tame acceptance of what has already *happened*. We’ll click our tongues, wag our fingers accusatorily, accept the judgment as an aberration and wait patiently for the forthcoming fascinations of just judgments. Bhopal, with all its effulgent hope, would after all sink into a post-realised Foucauldian mood.

1 *The Holy Bible* (King James Version), The Book of Job 12:2

The data has mostly been taken from *The Telegraph*, 8 June 2010. The opinions expressed are mine, though I gratefully acknowledge my debt to the conversations I had with Anandaroop Sen, Jishnu Dasgupta, Saumava Mitra and Upal Chakrabarti. I have purloined many of their ideas. Any appreciation accrues to them; all of the flak is due to me.

Picture Source:

1. <http://khatarkar.files.wordpress.com/2009/12/burial-of-an-unknown-child-th1.jpg>

2. http://www.ndtv.com/news/photos/albumdetails.php?id=7520&Album=PHOTO_GALLERY&AlbumTitle=Bhopal+Gas+Verdict%3A+Too+little%2C+too+late+%3F

On Africa's Bitter Pill: The Constant Gardener

Lauren van Vuuren is a lecturer in history at the University of Cape Town, South Africa. Her current field of research is Ulrike Meinhof and West German Terrorism. Broader interests include the history of documentary film, and the role of film in reflecting twentieth century historical consciousness.



Lauren van Vuuren



The Constant Gardener, Director: Fernando Meirelles, Producer: Simon Channing-Williams, 2005.

The Constant Gardener is straight out of Africa. It has all the soaring signatures of films made about the continent: Aerial shots of the vast landscape and its galloping animal herds, and marooned between these eternal wildernesses the wretched huddled masses of the urban poor. Picturing their clinging to life amidst colourful poverty, the camera sweeps along railway lines, above shanty towns of slate and brown, and roads that look like bleeding veins above the brown and red earth, and then roars suddenly to a silent halt amid the stillness and infrastructural solidity of western diplomatic missions. Here we meet our main characters, and here we come face to face with soft spoken evil in its worst form: Anonymous, omniscient multinational drug companies with their callous disregard for human life, particularly in its poorer and African form. The visual motifs of this film, in part so reminiscent of a long line of films that disaggregate Africa as a land of human

poverty and natural splendour wedded in an unholy matrimony, is yet far from being another blood diamond in the rough account of the continent's troubles. There are subtleties here that demand a respectful viewing, not surprising given that the film is based on a novel by that master of literary spy fiction most interested in the human and not the weaponry basis of our wars and woes, John le Carré.

The film is a complex murder mystery. At its centre is the quiet British diplomat Justin Quayle, played with gentle intensity by Ralph Fiennes, who is devastated by the mysterious murder of his activist wife Tessa (Rachel Weisz) in remote northern Kenya. Defying the intervention of his smooth-tongued colleagues at the British High Commission in Nairobi, who encourage him to accept the official verdict on the murder, Quayle sets about uncovering the truth about her death. Justin Quayle's journey is also an uncovering of his own truth, through the exploration of his deep and passionate love for a wife he realises he hardly knew. Following in her doughty and uncompromising footsteps, he finds that whilst he tended his Rhododendrons and mulled over mulch with his Kenyan gardener, his wife was following a trail of corruption that began with dead Africans and ended with corrupt British and Kenyan government officials in the pay of an unscrupulous multinational drug company.

The film is thus a veritable hotbed of current issues facing the African continent: The exploitation of the African poor by Western corporations, the epidemic poverty that makes populations more vulnerable to HIV and Aids, the uneasy and corrupt relationship between African elites and their Western counterparts, and ubiquitous political and social upheaval. For example, almost extraneously to the necessary momentum of the film, but nonetheless to devastating effect, the film includes a harrowing scene at an NGO Aid Station in the Sudan where roving bandits attack, rape and murder its hapless inhabitants whilst the Western aid workers are flown to safety in the nick of time. Indeed, in *The Constant Gardener*, Westerners are often pictured surveying these disasters of Africa from this 'view from above', be it in planes or large air-conditioned four wheel drives. Their point of view provides a gloomy cast for a continent as hobbled by stereotypical depictions as by its actual political and social crises.

And yet the world of the film is also inhabited by intelligent and articulate Africans, who are notably circumspect and ordinary as they carry out the business of surviving the same perils that the Westerners have the privilege of being rescued from. This is an important point: In a significant departure from a long tradition of 'buddy films' made about Africa, where the story of a black person is told through his friendship with a white person, this is a film where such cross-racial relationships are depicted as unexceptional and ordinary, rather than moralistic and revelatory. Justin Quayle is not discovering Africa's woes through a black person's eyes, but through his wife's activism, and her endeavours are interwoven with a series of equal and intense cross-racial relationships, the most notable of which is the one she has with the doctor Arnold Bluhm (Hubert Koundé).

In a further departure from more traditional cinematic depictions of Africa, the enemy at large in *The Constant Gardener* is not civil war, blood diamonds or famine. It is medicine. An unscrupulous international pharmaceutical company with significant infrastructural investment in Britain is testing a TB vaccine on people in the slums of Nairobi, and many of the test subjects are dying. There is a cover up. It is this cover up that Tessa was about to explode, that directly led to her murder. In Justin Quayle's subsequent adventuring, the plot is exposed and Justin then goes to his death at the hands of his enemies knowing that the truth will out. As much as this might seem to be the familiar tale of the courageous white man in Africa, who exposes wrongs against a helpless African population, there are once again important geo-political complexities being explored that render this story complex and challenging. The relationship between Western pharmaceutical companies and African nations struggling with

rampant HIV and TB, for example, is a vexed one. International Pharmaceuticals resist calls to distribute generic versions of expensive drugs that would improve the lifespan of people with HIV, whilst at the same time African countries such as South Africa and Zimbabwe have rejected offers of loan packages from the World Bank for the acquisition of HIV drugs because it would, they argued, further increase dependency and debt in the third world. At the same time, as Patricia Nell Warren declared in 2000, “AIDS policy is now a key world commodity—right up there with shiploads of computers, crude oil and wheat”.¹ It is this notion of medicine as a commodity that *The Constant Gardner* explores at great length. In the film, British government officials, politicians, doctors, consular officials and Kenyan politicians are drawn by the massive profits promised by the pharmaceutical company to assist in covering up its nefarious and unethical activities in the slums of Kenya. Economics trumps ethics, even for some of the more ambivalent characters in the film, who are troubled by their involvement in the cover up.

John le Carré is a writer ceaselessly concerned with the ambiguous and obsessive elements of human nature that render up our worst wars and conflicts. He is also a writer intensely concerned with the dispossessed of the earth. In *The Constant Gardner* he identified an enemy of the poor, in this case the African poor, that is indeed a wolf in sheep’s clothing: The rising economic power of international pharmaceuticals. Under the direction of Fernando Meirelles, famed for another portrayal of third world poverty in the acclaimed *City of God* (2002), the film version of *The Constant Gardner* offers a view of Africa that is both familiar in its clichés, yet brave in its muted but defiant vision of a continent not as pretty as its flyover vistas might suggest, but not so ugly and helpless as its exploiters, its stereotypes and its detractors would profess.

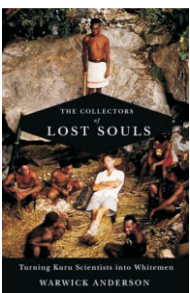
1 Patricia Nell Warren, “AIDS and the World Bank: Global Blackmail?”, *A&U Magazine*, 27 June 2000, accessed online at <http://www.globalissues.org/article/90/aids-in-africa#WesternPharmaceuticalCompaniesReactiontoAIDSinAfrica>, accessed on 23.05.2010.

Picking Brains

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Anirban Das



Warwick Anderson, *The Collectors of Lost Souls: Turning Kuru Scientists into Whitemen*, The Johns Hopkins University Press, Baltimore, 2008.

Academic monographs and articles, even in the humanities and the social sciences, have become easy to read in a certain sense. One expects a summary of arguments at the beginning and a concluding statement in the form of a paragraph or a chapter at the end. It is difficult (if not impossible) to move through the network of peer reviews if one does not provide an easy digest of arguments at the beginning or the end (or both). It is heartening to come across a book by a senior scholar that (refreshingly) defies the demands of easy summarisability. One has to read the whole book, preferably at one captivating go, to get an idea of Anderson's fascinating monograph. The analyses and the events form an intricate texture of readable narrative. That is what renders the task of this review difficult.

The book is a story of a disease. Kuru is a disease of the Fore people in the eastern highlands of New Guinea. Kuru, like many of our diseases, has had a definite history of emergence and a gradual tapering off. Like almost all other diseases, in its heyday of spreading death, it seemed to be one eternal phenomenon. Eternal yet localised: Localised geographically and ethnically. Anderson traces, on the one hand, the discovery— through the bringing together of multiple conditions, the symptoms afflicting many Fores (largely women and

children), into a single entity, thus bringing these symptoms under one umbrella term– of kuru by the white men. On the other hand, he also tells the story of how– in the frantic search for the origins of the disease in terms of geography and causality– the appearance of the entity in the population of the Fores was later fixed to a late date of the 1920s. This kuru was (at the end of the first decade of the twenty-first century one may almost use the past tense in terms of the demography of that specific ailment) a disease of the nervous system that started with tremors, often incapacitating, gait disorders, slurred speech, and in-coordination. It led to incontinence, choreiform movements, rigidity, inability to swallow, starvation, and death. Death came within a few months. Early symptoms included marked emotionalism, with excessive hilarity, excessive laughter on slight provocation, and slow relaxation of facial expressions. Hence the name ‘laughing sickness’. It was an epidemic restricted almost to a single population of the Fores, annually killing hundreds of people for a few decades.

The book is also the story of a man. Daniel Carleton Gajdusek (1923-2008)– who won the Nobel Prize in 1976 for his contribution to the research in kuru causation– had almost been a polymath. Starting with a career in physics, he shifted to the biophysical and biochemical aspects of medicine. A man following his convictions to the detriment of a convivial sociality in professional life, he embarked into anthropological journeys in the Fore territory with a rare ease. He read Dostoyevsky, Joyce, Mann and Kafka along with Kierkegaard and Nietzsche when he was not occupied with his primary research. He, unlike many of the other ethnologists in the field, loved the Fores as a people. Gajdusek ‘adopted’ Fore boys (with many of whom he worked in the ‘field’) to move them on his own expense to the United States of America, tried to provide them with education and training in certain professions, and, in the 1990s, ended up being convicted of paedophilia. The account of Gajdusek’s transactions with the Fores is not that of a loving peer falling victim to political correctness. Nor is it a story of a cunning paedophile conspiring to transport boys at low cost. It points at the mingling of patronising and using, of love and self-interest, and mostly at the difficulty of defining the moment when respectful love for the other becomes self-indulgent transformative aggression. Rather, it is the difficulty of drawing the boundary between these two aspects in the biography of a man.

Anderson describes, thickly, the reflections on possible causes ranging from the infective to the genetic, and depicts the rationale behind the gradual supersession of earlier theories (a process whereby the earlier is more often accommodated in rather than cancelled out by the new). In this process, epidemiologists, anthropologists and laboratory scientists, colonial administrators and indigenous people take part with heterogeneous yet critical inputs.

The book describes the workings of modern medicine in a global network. When one looks into the role of Gajdusek in the discovery of the dynamics of kuru causation, one invariably discovers the role of innumerable other researchers in the process. Anderson illustrates in meticulous detail the changes in the hypotheses of kuru-causation. He describes, thickly, the reflections on possible causes ranging from the infective to the genetic, and depicts the rationale behind the gradual supersession of earlier theories (a process whereby the earlier is more often accommodated in rather than cancelled out by the new). In this process, epidemiologists, anthropologists and laboratory scientists, colonial administrators and indigenous people take part with heterogeneous yet critical inputs. The field works and the dogged persistence of the anthropologist couple Shirley and Robert Glasse in their own deductions went a long way in establishing the link of the disease kuru with the practice of cannibalism in the Fores, a practice of eating the brains of the corpses of near relatives mostly prevalent in the women and children (who were by far the largest victims of the disease). Gajdusek’s own insistence on the action of a ‘slow virus’ was thereby not fully invalidated. Instead, a notion of contagiousness (propagated through food) in replicating protein structures

(and not in nucleic acids like the DNA molecules) could gain some ground in theories of reproducibility of ‘living’ matter. Anderson brings out with a rare clarity the roles played by numerous material, semiotic and human actors in the formation of a ‘medical problematic’ and its purported solutions. Power differentials mark, both overtly and covertly, these networks of actors in palpable ways. Anderson points to some of these markings in no uncertain terms. He also points at the blurring of identities. Kuru gets related to other diseases through similarities in brain changes and causative ‘proteins’: The scrapie in mice, the bovine ‘mad cow disease’ or the human Alzheimer’s disease and some other chronic degenerative diseases of the nervous system. Studying the cannibalism of the Fore obviates the ‘medical cannibalism’ of the scientist Gajdusek. May be, and this has not been spelled out by Anderson in unambiguous terms, one has to rethink the import of the word cannibalism. In the Fore cannibalism, overt, indicates intimacy— an attempt to retain the near relatives in one’s own body. In the modern scientist, the covert cannibalism is in the disinterested use of his objects— both human and non-human— though often in terms of an intimate concern at the level of the individual person. Gajdusek, for one, could not rest satiated in his scientific mission nor in his active intimacy with the Fores. One can barely use judgments of values in this setting. He, and other researchers in the field, had always been violating norms of informed consent for the Fores when they were acquiring— often through devious means— samples of blood, brain and other body parts. Here, value-judgments are not so difficult. Yet, as the scientists gather kuru brains, the kuru collects the soul of the wandering Gajdusek. It’s a two-way process, with a gradient.

The book is thus about the enmeshing of ethics and interests, of gifts and markets, of philanthropy and pleasure. This provocative book brings up, though not avowedly, one important question regarding the act of writing. Is it possible to address theoretical and abstract problems through empirical descriptions, rich and variegated in their implicit knowledge of those same problems? Anderson’s book goes a long way to accomplish the task, bringing in notions of networks of human and non-human actors, of ethics and politics embedded in epistemological projects, and of power differentials acting in those diffuse fields. It also shows the limits of this attempt. Thick and nuanced descriptions tease out ideological and ethical conundrums as hints and associations of thought, evocative in their implicitness. One still has a sense of the need to address them squarely in the face, in terms abstracted from their empirical contexts, though rich in specific enunciations. This, however, does not take away anything from the immense theoretical import of the monograph, or from the pleasures of its read. In a short review one has to leave some remarkable components of the book unaddressed.

Concerns have been expressed, in recent academic writings, on shifts in the relationship between ‘science studies’ and ‘history of science’. The latter seems to move away from the former inexorably to a classical historical narrative. Anderson’s book, in a fascinating way, shows how insights from science studies may turn histories of science into richer and more intricate narratives.



Map of Papua New Guinea showing the Eastern Highlands

Picture Source: http://upload.wikimedia.org/wikipedia/commons/9/97/New_guinea_named.PNG

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