

Filth, Food and Freedom: Public Health and its Changing African Objects

Preoccupied with gaps between bodies and the interface separating bodies and the non-corporeal world, public-health technologies exemplify the productive power of disciplinary space, which is the contextual condition of possibility for the identity of the objects within it. Following Armstrong's (1993) use of Mary Douglas's *Purity and Danger* (1966), one way of exploring this space is to view its characteristics as produced by the hygienic rituals codified within public-health practices.

At one level, hygienic rules are a means of identifying and keeping separate that which must be kept apart. To illustrate this, Douglas (1966) analysed the dietary rules in Leviticus and Deuteronomy which give a listing of animals, distinguishing between those which may and may not be eaten. She argued that the only way of understanding the allocation of animals to either of these two classes was the principle of completeness or 'holiness' which demanded that different categories of things were not confused.

In the firmament two-legged fowls fly with wings. In the water scaly fish swim with fins. On the earth four-legged animals hop, jump or walk. Any class of creatures which is not equipped for the right kind of locomotion in its element is contrary to holiness. (Douglas 1966: 55)

For example, because the eel and the shellfish live in the water but do not have fins and scales, they were part of an anomalous group and therefore unclean: "Everything in the waters that has not fins and scales is an abomination to you" (Leviticus xi, in Douglas 1966: 42). Analogously, 'dirt' or 'filth' – which feature so prominently in the discourse of public health – are essentially matter out of place, and rules of hygiene themselves function like religious interdicts to keep separate that which must be kept apart.

What Armstrong (1993) adds to this analysis is an examination of a further effect of pollution rituals for, in addition to ensuring the purity

of the spaces they are designed to keep separate, these rituals highlight the boundary itself:

The boundary between 'protected' spaces is a line across which pollution threatens to pass. But in closer focus it can appear to be more than a linear dimension: rather it becomes a space or region marked out by its own conceptual axes and containing its own anomalous objects excluded by the contextual classification system. This boundary line is a residuum of social order, a twilight place of outcasts, danger and pollution ... Seemingly within the line itself, in a space without volume, lurks threat and danger which cannot be ordered, only contained. This unruly region separates and defines the fundamental spaces of social life, yet somehow seems to lie outside of the social. (Armstrong 1993: 393-4)

This chapter follows Armstrong into this unruly space of productive power by analysing the public-health practices that from the second half of the nineteenth century have had as their object and effect the relation of the African body to public-health space.

Sanitary science and the emergence of a body boundary zone

During the mid-1900s a respatialization of illness occurred that for the first time made it possible to conceive of the volume of the African body as a distinct space alongside the physical space of the environment. Previously (see Chapter 4), disease illuminated not bodies but the characteristics of places, for the causes of sickness had been seen to reside in the interplay of the air, the soil, water and the sun (e.g. Kay 1834; Lichtenstein 1812). While this geo-climatic spatialization of disease sustained the technique of quarantine aimed at keeping diseased and non-diseased localities apart by preventing the movement of bodies between them, those bodies themselves (their characteristics, attributes, identities and so on) remained irrelevant and therefore unanalysed.

Around 1850 this public-health focus on places was reversed by a concern which replaced the geo-climatic space of old with a socio-physical one. This was 'sanitary science', and problematized not movements of disease into the body from the atmosphere, but rather the reciprocal exchange of energy and matter between human bodies and external space. This new gaze established as its effect and as the primary object of public-health surveillance the boundary zone which separated anatomical from environmental space:

Man lives in a medium on the surface of the Earth – absolutely necessary for the support of life and that medium is pure atmosphere. Essentially

necessary for the preservation of his health or for the recovery of his health when lost. Fish live in a medium and that medium is water. Water, either fresh or salt, if one poison the water in proportion to the amount of poison will the Fish sicken and die. In like manner if one poison the atmosphere, man will either sicken and die – in proportion to the amount of poison contained in the atmosphere, because the blood unless it can be subjected to the influence of pure atmosphere in its passage through the Lungs becomes hurtfull [*sic*] to the body, oppressive to the Brain, unfit for the reproduction of healthy tissue, the freedom from disease and the support and nourishment of the Body in General. (Fitzgerald 1859, in Cory Library: Folder 3, 200–1)

In this new regime it was the body itself that was the most prominent source of danger to atmospheric purity, for: 'A body in a state of disease is like a volcano in action and is constantly eliminating from the Lungs, skin and various organs of the Body Noxious matter and Effluvia hurtful to it and no longer to be endured' (Fitzgerald 1859, in Cory Library: Folder 3, 201). Purity of the body and purity of the atmosphere were therefore each contingent on the purity of the other, and it was through the deployment of rules directed at controlling the exchange of matter between these two categories of completeness that the African body entered the regime of sanitary science.

The 'Christianized Kaffir' as a public-health problem By the 1870s the boundary zone delineating anatomical from environmental space was itself located in a more encompassing pair of categories. On the one hand, the 'natural' and therefore pure category of 'tribal' life, and on the other hand the equally pure category of the European city and 'civilization'. In between was an indeterminate region that gave rise to the 'Christianized Kaffir' who, belonging to neither the tribe nor the town, was an anomalous object and so particularly hazardous to health. This danger issued from the incomplete 'civilization' conferred by 'Christianization', which altered clothing habits to interrupt the proper exchange of matter and energy between the body and the environment:

Among the ... Kaffirs, cases resembling phthisis are often met with; but I believe that most of these are cases of pneumonia becoming chronic through neglect. This is more especially the case among Christianised Kaffirs, because the wild Kaffir wears only a blanket, and when he gets wet, as soon as he returns to his hut he throws off his blanket, and does not sit or sleep with his wet blanket round him but lies naked on a mat before the fire. But the Christianised Kaffir, who wears European clothes, does not trouble to change them when he gets wet, as it is too much trouble, but keeps them on and sleeps in them, and is thus, through help of civilization,

more subject to bronchitis and pneumonia, the latter often through neglect terminating in abscess of the lung. (Egan 1877: 112)

Against this momentary focus on the two-way exchange of energy across the skin of the African, the gaze of sanitary science was, until around 1910, preoccupied with the unidirectional policing of matter moving from the African body into the 'atmosphere' absorbed by European bodies. Particularly hazardous were substances belonging to neither the body nor the environment (e.g. faeces, urine, saliva). It was therefore the bowel and the mouth through which these were expressed that emerged as the dominant objects in this nascent regime of sanitary science.

In 1888, for instance, it could be said that 'the Public Health at Kimberley and other Towns' (Fitzgerald 1888: 4) would be much improved by a sewage disposal system that kept separate categories of human waste which did not belong together.

[C]an it be conducive to Public Health to have a number of human beings congregated close together in Towns and Cities with a number of Cesspools and one Tub Closets containing fluids and solids in their midst, constantly undergoing fermentation, and giving forth foul emanations poisoning the atmosphere they breathe? Why should we mix solids and fluids together, thus making a poisonous and disease-generating mixture polluting the air? From the natural organization of our bodies, it was never intended we should do so. On the contrary, it is clearly pointed out to us that we should get rid of them as speedily as possible without mixture. (Fitzgerald 1888: 4)

Alongside faeces and urine, the 'microbe' was among the most threatening of objects inhabiting the newly discerned body-boundary zone, 'for there is now scarcely a medical subject ... which is not supposed to have its microbe or pathogenic organism' (Messum 1895: 268). The 'microbe' was less a discovery than a surveillance device, for in demanding that its passage through space be mapped it outlined those bodily regions across which disease-causing organisms might pass into the world of people, places and things. To wherever it turned, the sanitary gaze filled the environment with such organisms as they swarmed from the earth (Public Health Notes 1894: 75), from the blankets and bodies of the African (Fuller 1897: 43), from the 'tools, implements and c.' used by rural Africans (Impey 1896: 32), and from the mouth of the 'church native':

Properly conducted and careful enquiries ... will nearly always show a focus of infection. This in nine cases out of ten is the servant-maid; she is generally a church native, and almost invariably wears stockings. She, it can be

proved, has wantonly kissed the baby; it gets syphilis. The unsuspecting master also inflicts upon his offspring a chaste and paternal kiss and, as a partial consequence, he gets a hard sore on his glans or prepuce. Thus the disease gradually osculates the whole community. (M.O.M. 1894: 154)

By the turn of the twentieth century the body-boundary zone had thus expanded into a three-dimensional space that established the contours of the African body as an anonymous anatomical container and isolated as immanent sources of danger its points of greatest permeability to the external world. The occurrence of bubonic plague between 1900 and 1904 further insinuated this socio-physical space into the gaps between bodies by illuminating a series of dark corners in the cities which sanitary inspection revealed as especially dangerous owing to the dense intermingling within them of different bodies: 'Whole streets were inhabited by natives, and in some houses close to the leading thoroughfares the cellars were occupied by large numbers of men – Europeans, Malays, and raw Kafirs – all sandwiched together, living in a state of the utmost neglect, disease and vice' (Graham 1902, in Swanson 1977: 400)

If the occurrence of disease could be identified with such admixtures of different bodies, then its prevention demanded that those same bodies be separated out, and through their aggregation the minute interstices of contact between different bodies precipitated the formation of a massive new surface for public-health intervention.

Plague and the new hygiene of 'Location' A means of control through segregation, confinement and surveillance, the idea of 'Location' crystallized an otherwise indistinct relationship between the disorder of urban space and the production of disease. In revealing to the sanitary eye the failure of Africans to manage adequately the passage of matter across their body-boundaries, the plague offered powerful confirmation for the strategy of 'Location' as a means by which to combat such disorder. Its initial effect was to install the African body as part of the environment, as a threat to the European which could not be ordered, only contained. Giving evidence on the plague in Natal, Durban's Medical Officer of Health could observe: 'Of course, with an Indian or Kaffir population constant supervision is essential, for their ideas of sanitation are not sufficient, in my opinion, to allow them to live in any area where Europeans reside' (Munson, in Hill 1904: 9).

Between 1900 and 1904 the productive power of the plague as a disciplinary device was realized in the installation of geographically defined locations outside Cape Town (1901), Port Elizabeth (1903),

Johannesburg (1904), and a host of smaller towns, in each instance as a direct result of the plague appearing within them to shine a sanitizing light into 'every yard, hole and corner' where previously 'everyone ... [was] allowed to go except a policeman' (South African Native Affairs Commission 1905: 652).

However, the strategy of 'Location' transgressed the hygienic rules which demanded that bodies be kept separate to prevent their pollution via the dangerous accumulation around them of exhaled air, sweat and other substances that belonged neither to the body nor the environment. Even at the point of its installation, 'Location' was therefore a site for the resurgence of disciplinary surveillance to the interface between the interior of the African body and the environment. Arguing that local authorities were evading their responsibilities by using the African as a 'sanitary whipping boy', a 1904 editorial called not for the abolishment but rather the refinement of 'Location' as an hygienic strategy:

When such people are transferred from their own environment to one exacting a totally different habit of thought and practice the clear duty of the white man who has learnt his lesson is to pass that lesson on to them ... Our paramount duty is to face the burden of a better and more expensive hygienic supervision than is necessary with the man of white skin. (Editorial 1904: 71)

'Location' thus became a strategy which combined the repressive tactics of separation and enclosure with the subtle segmentations associated with discipline, at once to enable the sanitary segregation and surveillance of Africans, and produce them as 'docile' and 'regimented' bodies.

That Natives and Asiatics, other than those employed in domestic service, should reside apart in a specially allotted district of the town is ... highly desirable. These people have moral ideas and social habits widely divergent from those of educated Europeans, and this fact alone fully justifies such racial segregation. To the hygienist, however, the most convincing argument is the facility which is afforded for sanitary control, more especially in respect of communicable diseases. (Watkins-Pitchford 1908: 73)

By interpolating hygienic surveillance into its closed domain, the native location became an observatory for the minute surveillance of the sanitary behaviour of Africans. The effect of this was to revivify the earlier focus on the 'Christianized Kaffir' as an anomalous object produced in the unruly region between African tradition and European civilization.

The dressed native as object and problem Where previously the sanitary gaze to the African body-boundary had been preoccupied with monitoring matter passed out of it, this was now complemented by an equivalent focus on policing the substances that moved into the African body from the environment. Food, for instance, became the subject of close scrutiny and a device by which sanitary science elaborated the African mouth with teeth, which as the first point of contact for many substances entering it was a particularly dangerous part of the body-boundary zone. Thus, both Mitchell (1908) and Bruce Bays (1908) offered comparisons of the African's diet under 'natural conditions' and in the location: 'Consisting mainly of mealies, pumpkin, sweet potatoes, and sour milk ... with meat occasionally and as a luxury', the tribal African's diet was 'healthy and nutritious' (Mitchell 1908: 258). In contrast, the African in the location: 'may feed at home on the offal of beasts of the slaughter-houses, on coffee, perhaps condensed milk and again on white bread ... [T]he result is that the teeth tend early to decay, and to become organs no longer required' (Bruce Bays 1908: 267).

The minute surveillance of the African body-boundary enabled by 'Location' thus marked completion of the great cycle of interchange involving contamination and purification of the substances exchanged between the environment and the anatomical space of the body. For the African body now existed as the point where the arc of matter moving outwards was met by an equivalent arc of inward movement. Confirming this, a 1914 Tuberculosis Commission report (Union of South Africa 1914) matched each of its investigations into matter which departed the African body with an equivalent focus on that which entered it. Talking of the native's 'apparently ineradicable ... dislike to ventilation in his dwelling' the report observed:

windows, and ventilation openings he persistently blocks up. If possible he will always have a fire in his sleeping place. The hotter and stuffer the air the better he likes it. Added to this he invariably sleeps with his head wrapped up in a blanket. If the blanket were clean there would be no great harm in this, on the contrary it would act to some degree as a filter both to himself of the air he inhales, and to others of the breath he exhales. (Union of South Africa 1914: 103)

Complementing this attention to the nose and mouth as points where dangerous substances moved into the African body, these were now also visible as orifices that expressed dangerous matter into the environment:

all natives are in fact most careless and filthy in regard to their nasal and buccal secretions. He will foul his fingers with it and after 'cleaning' them

on his own bare leg, on the floor or the neighbouring wall of the hut, or anything else convenient, he may dip into the common eating utensil. (Union of South Africa 1914: 102)

Contemporaneous with the crystallization of the 'dressed native', McVicar had in 1908 argued for a system of medical inspection and health instruction in 'native schools' as a means by which hygienic habits could be inculcated in the African: 'It is they who are likely to spread infectious or contagious disease. It is their unhygienic habits and their ignorance that require to be remedied' (McVicar 1908: 314). Such suggestions directed to recruiting individual Africans into managing their own body-boundaries were, however, signs of a public-health regime to come, for it would be another thirty years before they began to find any sustained application in relation to the African. Instead, and cementing the invention by sanitary science of the dangers to health as residing in the lines between the anonymous anatomical body and the environment, the regime of sanitary science gave rise to a centralized control technology aimed at policing the movement of impurities across the body-boundary through tactics of 'prevention and suppression'.

Policing impurity: the Public Health Act of 1919 Until its formalization in South Africa's first Public Health Act of 1919, the requirement for a centralized health administration was evident more by its absence than in its presence. For example, editorials criticized the fact of 'similar health calamities [being] ... dealt with in different ways' (Editorial 1911), because 'Municipalities are not always intelligent bodies ... some doing nothing at all for a long time, and then, under the influence of panic and negrophobism, rushing into paths wherein angels fear to tread' (Editorial 1914: 121).

In 1918–19 the influenza pandemic once again highlighted neglect of the boundary zone between the body and the environment, an Influenza Commission report advocating 'the necessity of devoting immediate attention to the improvement of housing and sanitary conditions in slum areas and locations' (Union of South Africa 1919: 54). In the same year the Public Health Act No. 36 of 1919 established the Department of Public Health as a central coordinating body charged with standardizing the methods of observation and mechanisms for the 'prevention and suppression' of infectious diseases deployed by each local authority.

The end result of repeated inscription in administrative consciousness of the anonymous border between the mass of bodies in the population and the external environment, the Act gave the force of law to tactics for its monitoring and control. Its nine chapters and 161 sections

contained no mention of the person as an idiosyncratic individual with thoughts, beliefs or emotions. Rather, its network of hygienic regulations coincided exactly with the body-boundary zone between corporeal and non-corporeal space. Factories, for instance, should be designed to make provision for the prevention of sweating; the regulations governing housing laid down a complex of laws concerning ventilation, lighting, space, the storage of food and disposal of sewage, while the Act's 'Food and Drug Adulteration Laws' set out standards governing the nature, quality and composition of foodstuffs.

In 1923, these procedures found their first systematic codification in Reid's *Sanitation and Public Health*. This instructed readers in how to detect such sanitary dangers as the ill-ventilated room, which 'on entering rapidly from the outside the sense impression gives a good idea as to whether ... its air is fresh or stuffy, oppressive or smelly' (Reid 1927: 50); how to identify for various infectious diseases 'the channels of invasion, or ports of entry into the body' (Reid 1927: 264); and how to fumigate rooms and disinfect 'articles like furs, feathers, bound books and leather goods which would be damaged by steam or liquid disinfectants' (Reid 1927: 241).

Syphilis prevention and personal health In radiating regulatory tactics into the body-boundary zone, the great achievement of sanitary science was to manufacture this as a visible interface amenable to manipulation in the fight against disease. However, this was also its greatest failing, since while laws governing such things as the design of buildings and the quality of foodstuffs could be enforced with relative ease, the external regulation of more intimate bodily activities – such as bowel movements, bathing and sexual intercourse – could not.

Emblematic of this failure was the mid-1920s' recognition of difficulties surrounding the 'prevention and suppression' of syphilis in Africans. Since 1909 'special anti-syphilitic measures' (Colonial Secretary 1910: 1) had sought to prevent its spread by making the issue of passes allowing natives to be present in European areas conditional on their being examined and treated for syphilis. In 'urban areas to which the Urban Areas Pass Regulations apply' (Colonial Secretary 1910: 2), these made it compulsory for all male natives suspected of having the disease to submit to a medical examination for the purpose of its detection. By 1928, however, the Department of Public Health began to comment on the 'special difficulties' attaching to this repressive strategy, which because it did not extend compulsory examination to native females had little effect on preventing the spread of syphilis through prostitution:

Under the pass system obtaining in some of the Provinces, a measure of control can be exercised in regard to males, but action on these lines in regard to females is extremely difficult. Native females are frequently commercialized purveyors of the disease, and in the large labour centres of the Northern and Eastern Transvaal frequently operate in gangs. It was hoped that with the coming into operation of the Natives (Urban Areas) Act, No. 21 of 1923, it would be possible through the agency of matrons of Native hostels and otherwise, to exercise a measure of control and supervision over Native females and to exclude from urban areas undesirable and redundant Natives of both sexes, but up to the present this hope has not been realized. (Union of South Africa 1928: 47)

By 1930 these procedures were not only seen as ineffective, but as inducing effects opposite to their aims of syphilis control. On the one hand, they produced the suspicion that an increased prevalence of venereal diseases was due to 'free and convenient treatment facilities ... [encouraging] exposure to infection and consequent spread' (Union of South Africa 1930: 47). For even as it failed, the creative power of the sanitary gaze was still able to illuminate the African's 'moral' make-up as a potentially important link in the chain of prevention:

A large percentage of such patients is almost entirely 'a-moral' and many are without any feelings of shame or common decency. They will often freely admit to repeated exposure to infection, or even perhaps to incest; re-infections after a period of prolonged, troublesome, and expensive treatment are not uncommon. (Union of South Africa 1930: 47)

On the other hand, attempts to expand the system of enforced medical examination to include 'all natives in domestic service' (male and female) were found to 'arouse intense antagonism and resistance amongst the native population' (Union of South Africa 1930: 47), driving the disease underground where it was inaccessible to the centralized lines of sanitary surveillance. Accordingly, and in place of these prohibitive practices, it could now be suggested that 'tactful methods and friendly persuasion – coupled with suitable methods for voluntary treatment – will in most cases yield the best results' (Union of South Africa 1930: 47).

As the failure of sanitary science became increasingly evident in relation to not only syphilis, but also malaria, tuberculosis and other diseases, so public health mutated into an increasingly synaptic configuration of disciplinary power. Against the concern with 'prevention and suppression', this nascent regime of 'personal health' (Reid 1927: 346) crystallized around the new idea of 'health' as something to be achieved through training the habits of individuals towards greater

cleanliness, better diet and closer attention to the well-being of themselves and their families:

While the liability to contract infectious diseases depends greatly on the environment of the individual, the cause of constitutional diseases depends more on personal habits and ways of living and as to how far the rules of health and laws of nature are obeyed ... Public Acts and Laws are chiefly designed to promote the health of communities through improving environmental conditions, by removing anything insanitary liable [*sic*] to be injurious to the general health. Personal hygiene is mainly directed to the promotion of the health of the individual. It aims at increasing the vital forces of the body so as to prevent constitutional disease. (Reid 1927: 346)

The new vision of personal health found rapid expression in state commitments to 'the dissemination of knowledge of the simple principles of healthy living ... amongst all races and classes of the population' (Union of South Africa 1929: 1), and by 1930 the socio-physical space of sanitary science was rapidly being replaced by the psycho-social space of a new public health. Soon to be known as 'social medicine', its attempts to recruit Africans themselves into the surveillance of anatomical spaces and body-boundaries would 'recognise countless individualities ... each composed of different constitutions, habits and idiosyncrasies' (Armstrong 1993: 401).

Social medicine and a psycho-social space

Summarizing this shift in public-health power, Cluver's 1934 *Public Health in South Africa* stressed the primacy of tactics that could persuade individuals to monitor their own body-boundaries:

Our first aim will be attained when we have induced the individual to eat food in correct quantity and quality, to live in atmospheres with sufficiently high cooling power whose action is not neutralised by incorrect clothing, to respond to muscular exertion by suitable psychological stimuli, and generally to live in accordance with the findings of the science of physiology. (Cluver 1934: Introduction)

To induct individuals into such a regime demanded that the psycho-social factors inhibiting the adoption of healthy habits be identified, and social medicine was thus the origin of a lowering in the descriptive threshold of power sufficient to manufacture the previously irrelevant customs and beliefs of Africans as its analysable objects and effects. This expansion of public-health space beyond the body's anatomical contours into the intangible topography of beliefs transformed the

African into a more pliable entity than had been sustained by the regime of sanitary science. For, as Gale noted in 1938, the fundamental health problem was now *'the problem of how to win over an illiterate people, still loyal in thought and in practice to medical ideas and customs intimately associated with deep-rooted ancestral superstitions, to a confidence in and utilisation of the sciences and art of western twentieth century medicine'* (Gale 1938: 8–9, emphasis in original).

Intertwined with this emerging focus to the beliefs it installed behind the African's overt hygienic behaviours was the cognitive device of viewing hygiene as coextensive with economic factors and patterns of African domestic economy: *'No amount of medical attention or instruction in hygiene will avail unless the Natives possess the facilities for observing any rules and regulations that may be promulgated ... The observance of instruction in medical hygiene is intimately wrapped up in the economic factor'* (Kark 1934a: 18).

To establish this link between hygienic behaviour and the *'economic factor'* demanded not only that better statistics be maintained to *'investigate thoroughly the incidence of disease in the native'*, but also mechanisms of surveillance able to construct the interrelationships between such factors as *'accommodation', 'ventilation', 'diet', 'sanitary conditions' and 'superstitions and other racial traditions'* (Kark 1934b: 67). Illness was thus relocated from the elementary space of the body-boundary zone discerned by sanitary science into this complex space of multi-factorial causation, and the nascent gaze of social medicine required a new technology for mapping and monitoring its distribution. This crystallized in the roving device of the survey, which now became an increasingly prominent technique of surveillance alongside the older methods of observation from the geographically fixed points of clinics and notification offices.

Surveying a psycho-social space: problematization of the normal A system for fabricating immunity through the modification of individual constitutions, social medicine demanded a technology of seeing that could dissolve the binary division of the population into the ill and the healthy and so induct everyone into its network of visibility. Hence a key manifestation was its *'problematization of the normal'* (Armstrong 1995: 5). In relation to the African, this commenced between 1935 and 1945 with a swarming of the survey and its diffusion of a normalizing gaze into African schools, townships and rural areas, to bring everyone into the eye of this new public medicine through the medicalization of everyday life.

Established in 1934, the Society for the Study of Medical Conditions

among the Bantu (Kark 1935) had as one of its first projects 'a scheme for investigating mathematically several thousand native school children' (Editorial 1935: 3). Suggesting the novelty that attached to this new way of seeing was Achterberg's characterization of native schools and classrooms around Johannesburg as

an enormous virgin field of medical research lying fallow practically at the very doorstep of the medical school ... In native schools within the municipal area of Johannesburg ... there are enrolled at present 7,000 pupils ... Within a distance of 30 miles from Johannesburg, there are an additional 3,000 pupils ... The possibilities for research work are boundless. Accurate means for judging age and reliable age-norms are needed. There is the fundamental investigation ... of vision, hearing, nose and throat, teeth, nutrition, and the incidence of hookworm and syphilis. (Achterberg 1935: 10)

In the same year Orford reported on a 'somatometrical study of bodily habitus in the Bantu female' that delineated 'the normal types of bodily form' (Orford 1935: 41), and in 1936 Broomberg investigated the blood pressure of '250 apparently normal Zulu adults' to reveal the variability of this normality by showing higher average readings for town-dwelling as compared to rural natives (Broomberg 1936: 32). Fox and Back's (1938) survey mapped the relation between agricultural practices, nutritional status and health in the Transkei, while nutrition surveys (Anning 1938; Le Riche 1938) combined anthropometric measurements with home budget studies to draw a line between bodily dimensions, patterns of domestic expenditure, ideas about the nutritional value of different foodstuffs and occupation. Meyer's (1941) 'physical measurements of Bantu school children' offered 'indications regarding the processes of bodily growth' by which deviations from the norm could be detected, while health surveys of African school children (Becklake 1943; Kark and Le Riche 1944) provided a perceptual grid in which to locate individual children on a continuum of health through the normalizing inspection of 'build' ('linear, intermediate, lateral'), 'posture' ('satisfactory, fatigued, scoliosis'), 'skin' ('elastic, dry, rough, mosaic'), and so on (Becklake 1943: 30).

By impinging upon the bodies and minds of all Africans, the survey erased the earlier distinction between the sick and the well to manufacture everyone as ill.

Sit in your car ... and watch the people who pass to and fro along the sidewalk. They are folk, white and black, who make up the main bulk of our population ... Do they appear to be healthy? ... The answer is, quite definitely, no ... The people do not achieve that optimum of health which

we really mean when we talk brightly about an AI nation. (Anning 1938: 7-8)

In short, the survey superimposed a new psycho-social space upon the socio-physical space of sanitary science. This psycho-social space was a series of gaps between bodies that were important not only for the 'microbes' passing to and fro, but also for the meaning that flowed between them, and so could now be caught up in a systematic health education campaign directed to their hygienic modification and regimentation.

'To the back of the black man's mind': educating the individual The survey's problematization of normality established a new objective for the practice of social medicine. Since everyone was now ill this required that everyone be made well, and with the survey's elaboration as a perceptual technique there arose a complementary focus on analysing 'health propaganda' and 'health education' as components of an expressive technology directed towards the manufacture of a healthy nation. 'A Ministry of Health!' exclaimed the South African Department of Public Health in 1937: 'the nation must be made health conscious and health minded rather than sickness conscious and sickness minded' (Union of South Africa 1937: 26).

No longer only the passive object of a centralized Panoptical power, the individualized African of the survey was now becoming its vehicle, an active conduit of discipline which through proper education could be recruited into the machinery of this new medicine as his own overseer, exercising surveillance over, and against, himself. Hence the possibility of a public-health gaze that extended to the very 'back of the black man's mind':

Does the European doctor or Sanitary Inspector really believe he can get at the back of the black man's mind, or trace the history of an outbreak of disease among the kraals as a native can? I believe that the [best] approach to the black man is by the black man supervised by the white and also that the main attack must be educational and that it must be kraal to kraal ... The country people ... must be tackled at their homes, by visiting and demonstrations ... and the iron hand of the law is best hidden in the velvet glove of persuasion. (Park-Ross 1937: 29)

Confirming the synaptic nature of the disciplinary power productive of this new regime, Anning observed that through health education each individual should be made into his own diagnostician, for 'the root of national and individual health ... depends primarily upon diagnosis, and the primary diagnostician is the sufferer' (Anning 1938:

10). What this required was a technique to increase the efficiency of individuals in reading their own state of health, for so long as 'consciousness of social incapacity' instead of 'subjective state of disease' continued to guide the search for treatment, so would people continue to remain sickness- rather than health-minded. 'We must think in terms of the opportunity for everyone to maintain and develop their health, and of assisting them to detect and suppress the first signs of illness' (Anning 1938: 8).

With this transformation, the repressive legislation and 'usual herd methods of examination, when all and sundry are stripped and examined in the mass' (Union of South Africa 1937: 57) that sanitary science had applied to the control of venereal disease, were now 'contrary to usually accepted health principles in so far as they tend to destroy co-operation and sympathy'. Instead, and where compulsory examination in the pass office and native clinic did still occur, it was transformed from a ritual of repression into a relay for the constructive power of discipline. 'The ... medical examination ... is a channel for health education and propaganda ... and much could be done through this contact to awaken his [the African's] intelligent interest and cooperation in hygiene' (Union of South Africa 1937: 57-8).

Complementing the transformation of pass offices and clinics into relays for the dispersal of hygienic discipline was the new figure of the 'native health assistant', an ambulatory agent of health propaganda designed to internalize the vigilant gaze of social medicine within the homes and minds of everyone:

These men, of good address and of sufficient age to carry weight with their fellows, have a background of intensive instruction in the working of the human body, the meaning of infection, the methods of spread of infectious disease, and the prevention of that spread. They have been equipped to follow up cases of infectious disease, and the contacts of such cases; to gain the interest and the confidence of the sufferers and their families in order to encourage them to attend at the clinics; to deliver lectures on health topics in beer halls, cinemas and schools; to prepare health pamphlets in Zulu; to inspect and report on defects of housing and sanitation. (Anning 1937: 7)

The aim of health education being to recruit each and every individual into the service of monitoring their own body-boundary zones, this could be facilitated by having native health assistants promulgate a device such as Hertslet's (1946) 'score-card' for a 'better home' and 'better family' competition. Taken 'into the Native locations, townships, black belts and reserves' (Hertslet 1946: 22), the 'score-card' first analysed the sanitary environment of the home and garden into thirty elements,

each to be scored out of 10 or 20. The second part addressed twenty-five 'parts of the body' (e.g. eyes, gums, kidneys and bladder, sleeping, and 'mental'), each of which was evaluated for each family member according to its condition. For instance: 'Bowels: Open once or twice daily without medicine (3); No discomfort (2); No diarrhoea (2); No bleeding (1); No pain or burning (2)' (Hertslet 1946: 26). Completion of these sanitary and bodily inventories would establish for each individual and each family the reality of hygiene and health as inscribed in the relationships between the body and the environment, which once internalized would 'help their people to walk ... and practice the ways of clean and right living' (Hertslet 1946: 22).

Crystallization of health education as a tactic of health promotion also found its way into the native school. Through native health assistants and teachers specially trained in the subject, social medicine now realized the long recognized potential of the classroom as a site for the creation of individual health, where 'the learner provides in his own person the subject-matter with which both the training and the study are concerned' (Dugard 1944: 418). There was education and training in nutrition, domestic science and school gardening aimed at cultivating 'a taste for protective foods which will last him through life' (Dugard 1944: 418), while training in physiology, disease transmission and personal hygiene made each child's emotions the locus of their own sanitary supervision:

My experience of Native children has been that they simply do not mind having dried food and nasal discharges and flies all over their faces ... In other words, it does not seem to be much good telling a child *why* he should be clean ... Our real aim should be to create in him an active dislike of dirt, so that his reaction to it is emotional rather than intellectual. (McGregor 1944: 419)

Finally, and as the tactic by which discipline could engrave itself at the subconscious level of pride in the body, there was the new focus on 'physical culture': 'Knowledge of the body in action must be studied and through the application of psychological and hygienic principles along with a better appreciation of the dynamics of movement, physique may be fortified, resistance to disease increased, and thus life may be healthier, happier and more productive' (Shearer 1938: 13).

The 'physical education lesson' thus established an alliance between the free yet controlled movement of bodies and the regime of personal hygiene, as through the game of 'the mulberry bush', where to the tune of 'Here We Go Round the Mulberry Bush' were substituted verses depicting such hygienic rituals as washing the face, cleaning teeth,

hands, feet, combing the hair and running to school (Huntley n.d.: 78). Such games and exercises were at one and the same time a means of observing the body and disciplining it: 'While they are singing they should fit appropriate actions to the words ... The teacher should see that the actions are correctly performed, and that during the singing of the chorus the children skip or run neatly, with small, vigorous, skipping steps' (Huntley n.d.: 78-9)

The Polela Native Health Unit and the African as a person Deployed independently, the productive capacity of surveys and health education was subject to clear limitations. Alone, the survey was restricted to making visible patterns of health and disease in the population. Without this information, health promotion and health education lacked any clearly defined targets. To maximize their productive power required that the receptive technology of the survey be closely synchronized with the messages identified to the expressive device of health education. Ideally, the two should be fused into a seamless exercise of surveillance-subjectification, the dissemination of health knowledge occurring at the same time as the recording of surveillance information. In 1940, following Gear's (1938) proposals for 'experimental health areas' where continuous surveillance coincided with ongoing intervention, the Polela Native Health Unit was established in Natal to realize just such a fusion of surveillance and subjectification, and with it a concentration of discipline sufficient to produce the African as a person.

The geographical space of the Polelea unit was first rendered calculable by 'mapping', whereby the entire area was partitioned into subdivisions small enough for a single native health assistant to record the place, personal identity, family configuration and various indexes of sanitation, hygiene and health for the occupants of every homestead in his area. Into this objectified nucleus for the maintenance of 'population records ... and epidemiological data' (Union of South Africa 1941: 63) were then intruded an array of surveillance techniques, every one a conscious attempt to make visible the web of human relations and recruit each individual into this synaptic network of disciplinary power.

During 'home to home visits of ALL the homes in specific areas, regardless of the presence or absence of ill health in a particular home' (Union of South Africa 1945: 36), members of each family were encouraged to talk about sanitation, vegetable-growing, eating habits, sleeping patterns and so on (Kark 1942). This information was recorded on special cards that tabulated the relationships between health, education and employment indices for each individual in the family, such as the dimensions of rooms in the homestead; to what uses the

rooms were put and what furniture they contained; diet, and qualitative observations concerning the family's 'health consciousness'. The family as a network of interpersonal persuasion was thereby constituted alongside the individual as a key object and conduit of this social medicine, and any illness within it could be related to such intimate observations as the fact that 'poultry share this hut with the family during sleeping hours', and while 'the head of the family is keen to progress ... his present wife is an extremely backward person, lazy and unkempt, and the home, unfortunately, reflects her personality. It is kept in an untidy and filthy condition' (Kark 1944: 46). Available to doctors treating patients at the unit's clinic and in the schools during routine medical inspections, these cards joined the otherwise separate fields of visibility represented by the school, the clinic and the home, to make each patient and his or her social spaces an integrated and open field of medical visibility: 'Instead of being cyphers, each man and woman, each child whether at school or not becomes a living entity with a home and a background, with thoughts and behaviour patterns – and each becomes an important part of our lives' (Union of South Africa 1945: 36).

Extending the power of this gaze to produce the African as a 'whole person', the unit had by 1945 phased out its 'specialised disease clinics' due to their

'dividing the indivisible', namely the patient. To such an extent has this become the case that a person is known and classified by the disease from which he suffers. Should there be two or more main pathological entities, e.g., syphilis, dysentery and tuberculosis then the person is put into three separate pigeonholes ... It is our contention that this is harmful and often leads to neglect not only of understanding a person as a person but of even missing some additional pathological factors influencing the individual's health. The Health Unit ... must therefore strip itself of this 'dividing of a person' and must use specialists and special clinics only where the practitioner of social medicine finds it necessary in the interest of the patient. (Union of South Africa 1945: 36–7)

Complementing home visits by which the medical gaze pervaded the psycho-social fabric of the community it constructed, a corresponding series of devices replicated the pattern of surveillance established at London's Pioneer Health Centre, where surveillance of the community had been achieved by bringing the community within the centre's own walls (see Armstrong 1983: 36). In the same way that all schools in Polela were used as observatories of health status and conduits for the creation of health in the home, so the formation of a Polela People's Club, and Saturday 'nutrition clinics' (National Health Services Commission 1944:

8653) infused the buildings and grounds of the unit's headquarters with the power to monitor and mould the health behaviour of the Africans that visited them.

Community health

While recognizing the 'countless individualities' it had recruited into its synaptic web of personal hygiene, social medicine had at the same time been a totalitarian regime. For although the individual was its relay, personal idiosyncrasies and cultural variations were acknowledged more as barriers to cultivating a regimented health consciousness than as conduits to collective well-being. As Kark had noted in 1944 of the Polela Native Health Unit:

At the beginning we were met with very solid antagonism ... They did not understand these 'black spies' that the Government had sent out into their homes ... The trouble is that you are dealing with something around which there is a considerable number of beliefs. Our first job was to break down those beliefs. (National Health Services Commission 1944: 8650)

Against this totalizing tendency, and contemporaneous with Orwell's (1949) post-war celebration of a liberal-humanist subject, there commenced a reevaluation of African resistance to public health.

An analysis of resistance and the emergence of community In 1947 Kuper wrote on 'the concept of social medicine applied to some Bantu speaking tribes'. Noting that among the Bantu 'new ideas are seldom accepted with alacrity, especially if they involve action by the European government and if they attack fundamental and vital beliefs' (Kuper 1947: 55), this introduced a new way of seeing African resistance to European public health by analysing the 'political implications' of Bantu attitudes to health and medical practices. Reversing the direction taken by earlier assessments of African beliefs from the external perspective of the public-health official, Kuper's analysis adopted a frame of reference internal to the Bantu tribes she investigated.

Accordingly, Kuper could show how traditional medical practices were coeval with the structure of tribal authority, its hierarchical distribution of power, and an array of sexual and 'magico-social principles' (Kuper 1947: 59) which clustered around food and housing to ensure that 'diet, recreation and housing are never haphazard and uncontrolled', but followed 'traditional codes within the framework of tribal experience' (p. 58). The effect of this analysis was to reconfigure the African as an object of public-health practice by replacing the earlier

focus on regimentation through rational persuasion with the idea that social medicine should be synthesized with African institutions in general:

The modern European concept of social medicine is a historical development in a particular sociological setting. In Bantu society, with an entirely different background, we find a different approach to medicine ... To suggest that the African be simply 'argued out of his belief in witchcraft' – is useless, not because of any innate differences of mentality, but because of the different social conditioning. Our treatment of African health must therefore be regarded as part of the approach to African institutions in general. Only on that basis can 'social medicine' as conceived by twentieth century sociologists and medical men be made effective in the new environment of the Bantu. (Kuper 1947: 66)

Concretizing this shift by which the analysis of African resistance induced a current of public-health power within the capillary spaces of community force relationships was Schaap's (1953) paper 'Health Visiting Among the Urban Bantu'. This explored urban Africans' antagonism to health visitor instructions that premature babies be placed in special boxes to ensure they slept alone. Noting in some cases that the midwife's attempts to introduce the box to the mother were rejected by the infant's grandmother, the health education strategy was not to override but rather to coopt this newly recognized authority relationship:

Much talk and persuasion on the part of the health visitor was required to convince that most important person in an African home, the grandmother. Thereafter, she tended to think the box her own idea and its magical properties the reasons for the child's survival. It is well for any health visitor starting work amongst the Africans to realise the importance of getting the grandmother on her side. (Schaap 1953: 534)

In 1957, and based on a similar analysis of African antipathy to health propaganda which failed to acknowledge the internal structure of African society, Goddard described a new series of venereal disease films which replaced earlier versions that had employed white actors: 'They caused great excitement because of the local setting, Bantu cast and the narrative which was woven around Bantu domestic life, its traditions and customs' (Goddard 1957: 18).

Albeit only hesitantly, these scattered commentaries on resistance signalled the formation of a new public-health space premised on a new dynamic of disciplinary power. For rather than trying to erase them through force of reason, the new space of community health had

begun to transform the traditional structures and health beliefs of African society from anomalous objects into lines of force that could themselves be coopted into the production of health.

A community gaze Exemplifying the object of community as an effect of this nascent 'community health', Kark and Steuart observed in 1957 that 'while effective health education must have precisely defined objectives, an attempt is made to avoid substituting one rigidity (ours) for another (the peoples)' (Kark and Steuart 1957: 133-4). Thus, where health education aimed at 'change in the interests of progressively improving states of health', it should at the same time 'achieve its ends by means that leave inviolate the rights of self-determination of the individual and his community' (Steuart 1962: 65):

Health education will then be at odds with itself if it tries to perpetuate ... 'the vandalism of restoration', if it attempts to re-fashion society on the model seen through the refracting lens of the health worker's culture. Manifestly this applies with increasing force, the greater the difference between the social and cultural make-up of the expert on the one hand, and the community he serves on the other. (Steuart 1962: 65)

The recognition of cultural relativity reconstituted the codes of public-health perception. Social medicine had involved complete calculability of the psycho-social through its precise mapping as a clearly demarcated series of relationships between epidemiological disease distributions, personal habits and economic factors, from which flowed the precisely measurable objectives of promotive health. Now, the very precision that had enabled social medicine to itemize public-health problems was itself seen to be a problem. As social medicine had criticized sanitary science for dividing the indivisible in the shape of the individual, so the community gaze now criticized social medicine for its fragmenting of the community:

Whatever ends may be served by the necessary specific [*sic*] definition of clearly articulated targets, the range of targets should be based on the implicit recognition that the health and disease of a community cannot be described purely in terms of discrete items but also as a single complex, contributed to by the whole pattern of everyday living. (Steuart 1962: 68)

This 'single complex', which was the cognitive object of community health, could now begin to crystallize as a new strategy of attention localized illness and health to the interrelated points between which power was reflexively exercised by community residents. As Cassell (1962) observed in respect of 'community diagnosis', what 'would other-

wise appear as a series of inexplicable interrelated acts' (Cassell 1962: 238) on the part of Africans refusing health-centre treatment for tuberculosis, found their own internal logic when viewed through a knowledge of cultural patterning and the social situation:

A firm conviction existed that patients presenting symptoms of pulmonary tuberculosis were suffering from a disease that could only be treated by a skilled *inyanga* and about which White physicians could be expected to know little ... Should the Health Centre viewpoint be accepted, therefore, the patient was in danger of being feared and ostracized by the community. (Cassell 1962: 239-40)

'Community diagnosis' was, however, a mere precursor to the more important task of community treatment, which involved stimulating 'those processes of community in a community which might lead to active promotion of health' (Kark and Kark 1962: 9). One example of how such stimulation was to be achieved was the Steuart (1962) system for the cooption of 'primary groups' through the deployment of 'community structure files'. 'An index system of carding every group of whatever kind as it was "discovered" or use made of it in a programme' (Steuart 1962: 83), the primary groups it invented functioned as networks of concern which modulated the strains of everyday life to embed each individual in a self-regulating circuit of care:

Internal communication among the members is likely to be continuous and intimate and deeply toned by an everyday familiarity. Primary friendship groups could be expected to exert, on the one hand, conformity pressures of a powerful kind because of the deep-seated attractiveness of membership and the fundamental human urges for acceptance and belonging. On the other hand, they may be able to tolerate certain differences among the members without rejecting them, and when pressures to conformity operate in respect of these differences, to be so coloured by personal friendship that conformity will result without undue strain on the individual. (Steuart 1962: 82)

A direct consequence of the South African state's repression of public-health activities in the early 1960s (see Lapping 1961; Letlhaku 1961), 'community' was in the decade that followed noticeable only by its absence, an editorial of 1967 calling for 'the organization of community-orientated, curative, preventive and promotive medicine. If disease lies hidden in our community is it not our task to root it out?' (Editorial 1967a: 662). By 1970, however, and coinciding with the emergence into clinical medicine of a 'cross-cultural outlook' (see Chapter 9), the community gaze began to reassert itself. In 1970 Silbert could thus publish

a paper on 'the Cape morbidity survey'; in 1971 this was followed by a second morbidity survey in Uppington (Movsowitz 1971), and in 1975 an editorial announced 'the recognition of community medicine' (Editorial 1975: 32), which Spencer described as a 'specialist branch of medicine, which does not deal primarily with individual patients, but with communities, determines community health status and priority health needs by epidemiological techniques, and prescribes and makes operative the means optimally to maintain health' (Spencer 1975: 35). Epidemiology was the technique of choice for this rediscovered and finally formalized community medicine of the 1970s, and over the next decade there occurred a flurry of studies that linked patterns of health and disease to demographic, socio-economic, educational, familial and socio-cultural variables. This epidemiological renaissance installed what Power and Heese (1978: 409) called 'the new morbidity' ('behavioural disorders, adolescent problems, drug abuse and unwanted pregnancy are some of the areas covered by these terms'), and with its rise community health began to decline in the shadow of a new public-health object called 'lifestyle':

The lifestyle of a community and of its individual members is a product of the environment and the reactions of the community or individual to it. There is every reason to believe that the patterns of health and disease is [sic] determined to a great extent by the prevailing lifestyle. (Editorial 1978: 733)

Where it had previously recognized the factors productive of illness and health as immanent in community force relationships, the invention of 'lifestyle' dispersed the dangers to health into the environmental space surrounding communities. Here, it was less illness itself than the precursors of future illness that would become the target of a new socio-ecological focus to the extra-community space of 'risk' and 'risk factors'.

A new public health: the socio-ecological model

Since the 1980s, what has become known as the 'new public health' (Armstrong 1993) or 'socio-ecological model' (Goldstein 1993: Appendix B) has taken shape and embraced the population in a novel strategy of attention. As Goldstein noted, the emergence of this approach resided in a recognition that 'major sectors of the population are unable to make changes in individual risk factors' (Goldstein 1993: Appendix B) owing to their lifestyles being conditioned by sociological and environmental forces that transcend both the individual and the community.

Where sanitary science was concerned with the intrusion of nature into bodies, and social medicine and community health with the dangers that lurked in interpersonal space, the gaze of the socio-ecological model is concerned with the intrusion of the activities of those bodies into nature: 'The new public medicine has discovered that the by-products of economic and social activity can be dangerous and has committed itself to maintain the purity of the natural environment' (Armstrong 1993: 405). Intensely reflexive, the 'socio-ecological model' invents the individual, the community and the social as at once their own greatest sources of danger and the locus at which intervention should occur. Emblematic of this new focus was the concept of 'health promotion', which Tobias and Reddy defined as:

[A]ny combination of health education with related organisational, political and economic interventions designed to facilitate behavioural and environmental adaptations that will improve or protect the health of communities ... Many of these health conditions and broader circumstances that result in a compromised quality of life are not within the control of the individual. There is a need to acknowledge the gap between the rich and the poor and the limitations economic inequities place on an individual in adopting or resisting behaviour that compromises health. (Tobias and Reddy 1993: Appendix A)

The effect of this has been to extend the psycho-social space of interpersonal hygiene into a 'politico-ecological dimension', its contours delineated by the intersection of interdisciplinary and cross-sectoral modes of analysis and intervention. For instance, the risk factors surrounding violent injuries are transposed from the individual and the community into the subjectifying effects of repressive ideologies that here sustain implosive patterns of interpersonal violence and there explosive patterns of internecine violence (e.g. Butchart and Brown 1991). Through the surveillance of cigarette and alcohol usage, an insidious network of observation and caution now identifies the threat to innocent minds which resides in the products of the advertising industry and its 'particular ramifications for youth who are easily influenced by social factors as they attempt to develop a sense of identity' (Parry et al. 1994: 44). In relation to pollution, levels of bodily exposure to noxious gases and other wastes from car exhausts, coal-fired stoves and industrial plants are revealed through the monitoring of air and integrated into urban-planning diagrams and interventions aimed at altering the use patterns of fossil fuels (Seager 1993). Deforestation of the land in search of wood for fuel has further elaborated this 'green response' in the shape of new strategies for electrification and national

tree-planting campaigns, while the prevention of 'chronic diseases' (e.g. hypertension and obesity) is inscribed in strategies that interlink 'lifestyle' with departments of health, political parties, trade unions, large employers and educational agencies (Steyn 1993: 111), to position individuals, communities and societies in a great matrix of corporate, political, governmental and environmental forces.

Thus, whether the environment be that of the socializing patterns set in place by the dynamics of the economic and political order, or the physical environment as it is formed through the chemical outputs of industry and the built environment as it takes shape under the impact of informal settlement and low-cost housing, the space of identity in which the African body of the new public health emerges is a space of subjectivity and personal freedom, a space preoccupied with understanding and protecting the thinking, acting subjects which it fabricates from their own actions, and in that way maintaining the hygienic separation of human activities and nature.

Body production lines

To conclude this chapter's examination of public-health spaces and the identity of the African body it is useful to abstract the essential characteristics of each public-health regime by thinking about public health as a line drawn between bodies.

First, there was the geo-climatic model and its attendant strategy of quarantine by which a line was drawn between places. Second, there was the regime of sanitary science and its concern to police a line separating bodies from the environment. Third, social medicine and its preoccupation with recruiting those same bodies into maintaining a line between each other and the environment. Fourth, the strategy of community health which embedded groups of bodies in the larger social units produced by the lines it drew around communities. Finally, the socio-ecological model of the new public health and in its intrusion of lines of hygienic surveillance 'everywhere throughout the body politic' (Armstrong 1993: 405).

Correlated with these changes in the lines between bodies was the identity of the African body that each regime made possible. For geo-climatic medicine the line between bodies was a line without permeability, volume or depth. It recognized no separate bodies and no individualities, the rules of quarantine and their sovereign enforcement ensuring that these remained below the threshold of visibility and analysis. Sanitary science expanded this line into one with sufficient width and malleability to flow around and in between bodies, to con-

stitute the African as a distinct but anonymous corporeal space in the crowd, its contours delineated by the points of greatest permeability to the environment on which clustered the external control techniques of sanitary segregation. The advent of social medicine further expanded the dimensions of this line to make its volume more significant than its linearity. Its ballooning into the space of mind that was its effect thus allowed the African body to crystallize as an individuality invested with traditions, superstitions, customs, emotions and so on. With community medicine, the volume of this line expanded further outwards to fabricate the edges of a shared social space, the borders of which were folded in on themselves and coterminous with those of the communities this medicine discovered as encasing the individual and the interpersonal. Finally, with the new public health, any vestige of linearity has disappeared, to be replaced by a multi-dimensional 'presence' that invests and sustains the African body as a reflective subject and conduit of an all-embracing socio-ideological context of economic and political activities.

The power of public health to invent, sustain and transform the social body and the various types of individual and aggregate bodies that have materialized within it does not reside within the ordered spaces and categories of health and wholeness that these lines protect. Rather, the productivity of these technologies emanates from the chasm between these regions of completeness, in the abyss separating the fundamental spaces of social life that over the last 150 years has, from its beginnings in the slender and almost invisible line of quarantine, 'rolled back across the landscape, revealing a vast space of limitless dimensions in which the social and the subjective would crystallize' (Armstrong 1993: 409).

Birth of the Bantu Clinic

In *The Birth of the Clinic* Foucault (1976) set out the practices that in Parisian hospitals at the end of the eighteenth century relocated illness from the two-dimensional surface of the body to a point within the three-dimensional volume of an anatomical body: 'In anatamo-clinical experience, the medical eye must see the illness spread out before it, horizontally and vertically in graded depth, as it penetrates into the body, as it advances into its bulk, as it circumvents or lifts its masses, as it descends into its depths' (Foucault 1976: 176).

This final substantive chapter offers a similar analysis of western clinical medicine and its production of the African. In clinical nomenclature the term 'Bantu' was preferred over 'African' until around the 1970s, and in keeping with the history of the present is also the term used here. Defined geographically, 'Bantu' designated all native peoples of Africa south of the so-called 'Bantu line' drawn across Africa from near Mount Cameroun on the west coast, keeping north of the Congo River and Lake Victoria, until the east coast at a point just north of Mombasa.

Although missionary hospital medicine had engaged with its own very peculiar African body somewhat earlier, it was only in the 1930s that the Bantu body started to become an object of secular clinical concern. As Bernstein observed in 1938: 'It was not until comparatively recently that the Bantu peoples existed for the [medical] student as a problem' (Bernstein 1938: 28). By 1973, the sheer repetition of Bantu clinical practice had so imprinted the reality of the Bantu body as different to the European body that Kloppers, president of the Transkei and Ciskei Research Society for investigating disease in rural Africans, could note: 'When I do a ward round at the White hospital and then walk over to the Bantu hospital, I truly have to change over in my way of thinking; I have to take one computer program out of my mind and substitute another marked "Bantu" to work there' (Kloppers 1973: 287).

Consisting in techniques such as palpation, auscultation, invasive instrumental inspections and surgical investigations, the clinical gaze

plumbs the living body to construct its most intimate depths and darkest recesses as visible objects of medical manipulation. Correlated with the intimacy of this gaze was the compactness of the objects that were its effects, and it was in the Bantu clinic that the African body achieved its greatest density.

A 1934 description of 'a day in non-European casualty' afforded a glimpse of how even in its earliest configuration the Bantu clinic produced the African patient as quite literally a lump of flesh:

You start in on the crowd which has now extended ten deep, and wonder if they've been breeding while you were away ... You go into the female cube and find about six perspiring masses of flesh; listening to a chest you hear the wierdest [*sic*] noises, and you realise the steriliser is the cause of it. You sing out for it to be turned off and return to the chest. (Casualty Officer S.S. 1934: 36)

This was a gaze that further divided the body into a series of disconnected segments defined by the pathology that was seen. Here 'a good T.B. chest in the cubicle – one at a time may examine'; there 'an interesting skin case'; and elsewhere 'cases of syphilitic ulcers, mucous patches and gonorrhoeal ophthalmia ... quickly dealt with by sending to Rietfontein' (Casualty Officer S.S. 1934: 36–8). The African as a fragmented collection of body parts and lesions was more than the reductive fantasy of a callous practitioner anxious to display an heroic capacity for clinical work. For this first regime of the 'Bantu clinic' coincided with a wider practice of pathological anatomy, which in actively creating a distinct 'Bantu anatomy' provided the corporeal context necessary to the unfolding of this African clinical practice.

A Bantu anatomy

In 1937 Dart concluded his *Racial Origins* by setting out a future where the Bantu body would be subject to the same intensity of investigation as had the European body in the '400 years since Vesalius':

The background of our picture has been limned; various highlights have been tentatively painted in; their gaunt relief will be subdued by the labours of those artists whose detailed work is essential to the masterpieces of the future. Their books are works of the time to come and will unquestionably appear when an army, equal to that which has laboured in Europe over the last 400 years since Vesalius, has been organised to collect information about the Bantu similar to that which has been garnered over these centuries concerning Europeans. (Dart 1937: 102)

Frankenstein-like, the anatomy and physiology of the passive body of the African patient began over the following decades to be assembled by the practices of the clinic. 'Every day, instances of variation in some anatomical feature or other are brought to light in work on the Bantu on the operating table, in the post-mortem and in the dissecting-hall' (Tobias 1947: 17). Organ by organ (e.g. the heart [Malherbe 1934]; the intestine [Van Velden 1943]), bone by bone (e.g. the skull [Galloway 1941]; the pelvis [Wells 1933]), and limb by limb (e.g. the thigh [Boshoff 1935]; the hand [Goldberg 1941]), its attributes were isolated and displayed for scrutiny alongside and in comparison to the European body. Thus, what this medicine demanded and what these anatomizing techniques produced was 'a monograph on the anatomical peculiarities of the Bantu', a 'Bantu anatomy' (Tobias 1947: 18) precisely equivalent to Gray's.

As pathological anatomy opened it up to invent and compare its configuration to that of the European body, certain organs, bones and systems of the African body attracted more intensive scrutiny than others. For instance, Sutherland-Strachan published in 1932 one of the first papers to examine what would become colloquially known as the 'Bantu liver', which was a particularly sensitive site from which to monitor the relation of Africans to the elements, minerals and alcohol its pathological analysis revealed to be present in their diet (Sutherland-Strachan 1932). A means of explaining the 'strange difference' between European and African women in 'the obstetrical sphere' (Broomberg 1935: 11), the pelvis of the Bantu female would also become the epicentre of more intensive study, as reflected in 1956 by the publication of *Bantu Gynaecology*: 'Less than twenty years ago the Bantu were an exotic growth to the gynaecologist. Now this branch of the human race has been received in orthodox gynaecological circles and its womanhood forms for the observer an entity' (Charlewood 1956: 1). The African heart was singled out due to the 'social anthropological interest' (Elliot 1953: 29) attaching to findings that it might differ anatomically from the European heart (Brink 1959; Sandeman 1965; R. Singer 1959), and because it was affected by a pathology so foreign to that seen in Europeans as to be labelled 'cryptogenic heart disease' (Higginson et al. 1960). Other anatomical applications analysed the African body's external surfaces, such as the pigmentation of the skin (Wasserman and Heyl 1968) and of the skin within the mouth (Van Wyk 1970), because 'the various patterns which skin pigmentation may assume are not always appreciated. Incorrect interpretation of a perfectly normal appearance may therefore result' (Van Wyk 1970: 177).

These and other applications of pathological anatomy furnished

doctors with an intimate familiarity with the African body's otherwise dark and unknown interior necessary to distinguish correctly the signs of real pathology from those that were mere phantoms of an eye, ear or hand unfamiliar with what was 'normal'. As Wells (1949) noted of the African body where he compared it with the European body:

[T]he anatomist may expect to find differences widely distributed throughout its structure. These can hardly fail in every case to exert an appreciable influence on function. Immediately they assume a practical bearing on the clinical sciences ... since it is agreed that normal function is best preserved or restored by maintaining or re-establishing normal structure. (Wells 1949: 86-7)

This anatomy was not a stable mechanism of normalization and clinical correction, though. From its crystallization in the 1930s, Bantu anatomy would for the next thirty years continue to consolidate itself. From the mid-1960s, however, it began to run alongside a new component in the Bantu clinic that permitted doctors not only to see the pathology but also to hear what patients said as signals of their physiological and emotional interdependence with a more encompassing socio-cultural domain, which by the late 1970s was formalized in the discipline of 'community health' (see Chapter 8). This produced the body of the individual as coextensive with the communal body, and by 1978 Tobias could thus replace the device of an individual Bantu anatomy with that of an aggregate African anatomy:

While anatomy and physiology deal with the standard individual, [physical] anthropology is the science of the group. Herein lies its great importance in a medical and dental school in this last quarter of the twentieth century; for it is with the group that community health has to deal ... Just as one has to study the anatomy and physiology of the individual as a groundwork for training in personal medicine ... so too does one need to study ... the anatomy and physiology of groups of men or communities, as a baseline for the later emphasis on community medicine and quest for community health. (Tobias 1978: 1067-9)

Turning from this synoptic genealogy of the Bantu anatomy this chapter now examines the African patient as an object and effect of clinical practice, from the 1930s to the 1990s.

The African patient as a lesion-containing body

The Bantu clinic's earliest incarnation developed around the perceptual technique of triangulation involving symptom, sign and pathology. The

symptom was a marker of illness as experienced by the patient. The sign intimated disease as elicited by the physician through history-taking and physical examination, and both symptom and sign pointed to an underlying lesion that was the disease (Armstrong 1995: 393). In effect, the patient was the lesion, and as an overture to physical examination by which the lesion was pinpointed deep within it, the doctor's task consisted in 'provoking the lesion to speech' (Armstrong 1984: 738). Pathology itself being voiceless, this could occur only through the surrogate medium of what the patient had to say about where, how and when the pathology made itself known, to problematize all patients who were not fully competent to speak for their pathology.

It was around this component of the clinical gaze that contemporaneous with the 1930s fabrication of a Bantu anatomy there crystallized a discourse devoted to identifying the characteristics of African patients that might limit their ability to speak on behalf of the lesions within them. Initially these writings were somewhat anecdotal, such as Grobbelaar's 1934 identification of 'the snag' that 'lies in the taking of the history of the case, for ... [the African patient] thinks that he is helping you ... if he answers every question in the affirmative' (Grobbelaar 1934: 14).

For instance: Question: 'What do you want?'

'Nkoos, I weep because I am ill.'

'How are you ill?'

'My whole body is ill.'

'Have you pain?'

'Yebo, Nkoos.'

'Where is the pain?'

He points to head, chest, stomach with a sweeping downward gesture.

'Is the pain in your head?'

'Yebo, Nkoos.'

'Is the pain in your stomach?'

'Yebo, Nkoos.'

'Is the pain in your chest?'

'Eheu! YEBO, Nkoos.'

In other words 'You've got it.' (Grobbelaar 1934: 14)

Confirming the correctness of this procedure when examining Africans, Dowie Dunn (1939) spelt out its principles: 'If there was no obvious evidence of disease, one talked in general terms, stating that with this sickness sometimes one got a headache or bellyache and so on. The native always gave the show away by showing definite interest when particular areas of his body were mentioned' (Dowie Dunn 1939: 51).

In 1943 the first edition of Gelfand's *The Sick African*¹ systematized the scattered recommendations of practitioners such as Grobbelaar and Dunn to formalize the notion that clinical practice with African patients 'involves an entirely different angle of approach to investigation and treatment' (Gelfand 1943: Preface). In its chapters dealing with clinical practice, *The Sick African* confirmed the negative significance of what the African patient had to say. Despite a twenty-six-page chapter on 'The Patient' – 'as a patient, he is well behaved, docile and submissive (Gelfand 1943: 6) – and a twenty-page chapter on 'The Examination', what the patient said was mentioned only to alert doctors to how these words might confound apprehension of the pathology:

[D]ifficulty in obtaining a good clinical history is presented by the patient himself ... He will not speak readily or communicate freely ... He has little conception of time and seldom knows his age ... Often enough, a few hours later, he will give an entirely different account. So the doctor must often rely upon the conclusions which the clinical findings enable him to draw. (Gelfand 1943: 28)

In 1948, Keen published a further exposition on diagnosing disease in the African body. Titled *The Psychological Approach to Bantu Medicine*, this advocated a number of methods for making the virtual voice of pathology audible through the noisy 'mixture of magic, religion and medicine which forms the background of the Bantu's mental reactions' to clinical care (Keen 1948: 6). For instance, because 'the taking of a long history goes against the grain in the Bantu' (Keen 1948: 8), and to mimic the ways of the witch doctor, the clinician should know even before talking with the patient where in the body the pathology was. To achieve this, a practice of surreptitious surveillance in the doctor's waiting area, achieved by

sending an orderly among the patients sitting outside my consulting room collecting names and tickets. He would tactfully find out what was wrong and as a result, I always had on my desk a list of names with major complaints. The patient would walk into the room and I would look him over and say 'Take off your shirt, I want to examine your chest' or 'For how long have you been coughing,' and then during the examination I would get my history knowing it would be as accurate as is possible in a Swazi. (Keen 1948: 8)

Further, in physically examining the African the course traced by the doctor's hands towards the lesion should reverse the direction taken by the hands on European bodies so that the patient's confidence would not be lost along with a chance to locate the pathology:

In examining a patient ... go for the main pathology first. For example, you have been taught that in palpating an abdomen, where you suspect the possibility of appendicitis you must start your examination in the left iliac fossa and work across to the right side. The idea of course is not to stir up any pain or guarding. That is fatal when dealing with the raw Bantu, as he will at once think that you do not know what you are about. (Keen 1948: 9)

Similar recommendations appeared two years later in Storr's 'Medical Diseases in the Bantu' (1950), and Brebner's 'Surgery in the Bantu' (1950). For Storr, 'Mr. Medical-diseases-in-the-Bantu' (Storr 1950: 49) was a particularly difficult patient in which to establish the truth of the pathological lesion because Africans lacked the historical consciousness needed to reproduce the lesion's chronological dimensions: 'Thus it is very difficult to obtain concrete answers to questions where time is really concerned. For how long has the pain been present; or when did he first notice that lump; when did he first start coughing up blood?' (Storr 1950: 50). Other obfuscating factors included 'the pigmented skin' which hindered the identification on physical examination of such conditions 'as early jaundice, anaemia and cyanosis' (p. 50).

Transfer of the lesion from the body into the abstract space of diagnosis was merely a precursor to treatment. Where this entailed ongoing therapy it demanded that the same lesion exist as an entity within the patient's own consciousness so that for its duration he would monitor it. But the African's 'concrete mindedness' and envelopment in a world where sickness emanated from bewitchment or ancestor influences meant that even this could not be assumed. The clinical gaze thus configured itself into a technique for training the patient's consciousness to produce the same corporeal dimensions of the lesion as seen by the doctor:

The Bantu, if he sees the trauma, can understand what's what and he then recovers because his tissues also have an immunity to infection. Years of repeated wounds give his tissues a certain immunity to infections. But woe betide him if that infection is hidden. If it is somewhere in his liver or his lung where he can't see it, he gives up the ghost very easily. It is in such a case that I think it worth while if you can spend the time, in simple language to say to him, 'now look, you have got this inflammation inside your body; it has to run its course; we'll try and control it.' (Brebner 1950: 47)

This was a means of recruiting the African into the heart of clinical discipline as his own insightful physician, and for Keen involved showing the pathology on the X-ray, the urine being tested, and letting the patient 'look down my microscope. He will probably not see anything, but it will give him something to fix his mental reactions' (Keen 1948: 9).

While it was the passive body containing the lesion that filled the medical gaze in this first incarnation of the Bantu clinic, the consciousness of the patient was not wholly absent. It is, however, incorrect to argue that this momentary surfacing of how the African patient conceived of his own body represented the tip of a subjective iceberg being discovered by a medicine edging towards a more humanist approach and the 'whole person'. Instead, these techniques of consciousness were directed to the opposite end of having the patient objectify the disease contained within his body. Problematization around 1960 of the African patient's thoughts and feelings as positive objects of clinical medicine therefore represented a break from this old regime. For the African patient as an emotional being was less a discovery of humanist enlightenment than a medical surveillance device to 'illuminate the dark spaces of the mind and social relationships' (Armstrong 1984: 739) within which it occurred.

An emotional patient The second edition of Gelfand's *The Sick African* (1947) merely extended the range of physical pathologies that doctors should seek within the African. The third edition's inclusion of new sections on 'psychological disorders' (Gelfand 1957: 533), and the 'effect on work and the importance of knowing the African' (p. 791), thus constituted a reconfiguration of clinical power that allowed for a patient that was more than an anatomized body containing a lesion. Now Gelfand could argue that the African patient's psychology was an important component of the clinical encounter: 'It is not merely a pathological problem. It is a problem which involves the appreciation of his outlook and his attitude to disease. One must know not only the diseases of Africa, but also the people with whom we are dealing' (Gelfand 1957: 791).

A 1960 paper by Findlay (1960) analysed 'the emotional pattern of the tribal Zulu as it affects pre-anaesthetic assessment and management'. Confirming the psychology of the African patient as an important effect and target of this new clinical regime, Findlay observed that where the patient was a 'tribal Zulu', it was important the anaesthetist pay special attention to this function owing to the culture-bound tendency of such patients to mask the 'stress' occasioned by fear. While emotional capacity was equally well developed in Europeans and 'Zulus', in the latter

Fear is deceptively masked by the absence of its outward manifestations. Thus the usual reaction to stress can be described as autonomic rather than vocal. The Zulu shares the belief of other warrior races that courage, as

such, should be regarded as a primary virtue, and any display of fear as contemptuous self-indulgence. The psychosomatic implications of this are the actually exaggerated responses anaesthetists encounter daily in the Zulu as a result of moderate physiological and pharmacological interference. (Findlay 1960: 854)

Accordingly, anaesthetists working with patients from 'warrior races' should avoid being 'misled' by their outwardly placid nature and anticipate the emotional infrastructure this concealed. Careful 'psychological preparation' was therefore essential (Findlay 1960: 855).

These works marked a new analysis of disease and its indicators that involved a reassessment of the African patient. Just as the emotional infrastructure of the Zulu patient recognized by Findlay (1960) meant he should not be mechanically pumped with anaesthetic, so at a cognitive level the patient 'cannot be regarded as an open vessel ... or as a vacant vessel, ready to accommodate whatever the doctor wishes to instil in him' (Abramson 1960: 365). Reciprocally, the lesion which the earlier regime had assiduously isolated from the context of the person, family life and culture, now came to serve as a relay for illuminating precisely these factors, and these in turn as a locus of clinical treatment. Illustrating the practical implications of this novel concern with the psycho-social, Crowhurst-Archer (1960) observed that tuberculosis among Africans occurred within a 'patriarchal society composed of large family groups governed by primitive taboos (Crowhurst-Archer 1960: 243). Accordingly, treatment of the individual as an individual would reduce the body's healing capacity by arousing resentment on the part of others and concomitant 'emotional breakdown' of the patient. The entire social unit in which tuberculosis occurred should thus be made the patient, and: 'To this end the wards of the admission blocks of some hospitals where Africans are treated are only separated by walls 3 feet in height so as to preserve the sense of community life' (Crowhurst-Archer 1960: 243).

An emotional component of illness having been identified within the shifting social spaces between bodies, a clinical method was now required to map these social spaces. Since they could be known only through what the patient said, illness was in effect being converted from what was visible to what was heard. 'The Language of the Patient' (Campbell 1961; Editorial 1961) thus advocated a thorough assessment of the doctor's capacity to understand what the African patient might say:²

It is morally wrong for any doctor to practice for gain unless he is able to communicate direct with them [*sic*] in a language which they understand

well enough to express accurately, not only the overt symptoms of their physical illnesses, but also the finer nuances of their thoughts and emotions, and the true nature of their hidden hopes and fears. (Editorial 1961: 986)

This 'moral' imperative to study the intimacies of African patients' experiences and thoughts was less an ethical necessity than a discursive device to mobilize psycho-social surveillance, and it was precisely towards establishing 'the true nature of their hidden hopes and fears' that the mechanism of the patient survey was first directed in 1961.

In 'What is Wrong with Me? A study of the Views of African and Indian Patients in a Durban Hospital', Abramson, Mayet and Majola (1961) confirmed the distribution of illness in the previously dark vaults of the subjective and the social by asking patients

a number of general questions concerning the illness, what the patient thought or had been told about it, and the steps he had taken. The patient was also asked whether he thought his illness was related to his food, work, smoking, drinking, or worries, whether he thought he had a 'Bantu disease' or had been 'tricked', whether he thought he might have inherited it or got it from somebody else who was ill, and whether he thought it might be a punishment, or result from any act or omission on his part. (Abramson et al. 1961: 690)

Invention by the patient survey of the social interstices which shaped the body and emotions extended illness well beyond the lesion in the body. There could thus emerge 'urbanization' as a device by which individual African bodies were made coextensive with an aggregate body defined by the factors specific to African culture and tradition.

Urbanization and a cross-cultural clinical gaze Since the early 1900s the idea of 'detribalization' had been installed by the psychological sciences (see Chapter 7) and public health (see Chapter 8), to explain the heightened proclivity of Africans to behaviours that increased their exposure to disease and their tendency towards 'impulsive' aggression. The clinical notion of 'urbanization' etched a far deeper line that ran not only through culture and behaviour, but into the very physiology and biology of the body, to render these inner systems resonant with their social and cultural context. By 1964, studies which some thirty years earlier had been the exception (e.g. Broomberg 1936: 31-2) had become the rule. Thus Seftel's (1964) study of diabetes in African patients attending a Johannesburg hospital could note that 'urbanization ... appears to be a potent diabetogenic factor ... The condition is rare in rural Africans but common in those living in and around cities' (Seftel 1964: 82). Indexical of these urbanizing diseases were those affecting the stomach

and the bowel, which from the 1960s became the pathological markers of African urbanization, magnified within the clinical gaze by the cognitive device of 'psycho-somatic' theory.

As Mirvish noted in 1962: 'there has emerged an increasing knowledge of the nature of symptoms in the study of such conditions as headaches, migraine, and many skin-conditions of nervous origin, and of the effects of the emotions on the gastro-intestinal tract, the stomach, and the bowel' (Mirvish 1962: 210). This fabrication of a new class of illnesses defined less by the lesion than emotional and attitudinal patterns called for an equivalent modification in the gaze of the doctor, who must 'be led to appreciate the close and inevitable link between psyche and the soma, and the way in which the one works on the other' (Elliot 1964: 148). A year later, Crowhurst-Archer consolidated this new interest in the patient as an integrated mind and body by advocating that psychiatry's prominence in the medical curriculum be increased, so as to introduce doctors 'to the problem of individual differences and their statistical treatment, the problem of normality and the problem of inter-personal relationship. It should ... prepare him to see *the person* in the patient' (Crowhurst-Archer 1965: 635).

Complementing this new interest in the 'person in the patient' was a reassessment of the place of clinical health education. For if illness was a pattern of emotions, then the categorization of patients into the sick and the well on the basis of the presence or absence of a lesion was no longer adequate. Instead, everyone was potentially a patient, and illness could be established even before becoming manifest through scrutiny of the social fabric it formed a part of. The *South African Medical Journal* in 1967 explored the implications of this new gaze for the clinical examination itself. Because 'some cultures are in equilibrium but others are undergoing change in the process of industrialization and urbanization which results in cross-cultural conflict' (Editorial 1967b: 41), it was essential that doctors 'who work in multiracial communities' understand and interpolate these cultural factors into their clinical practice:

It is advocated that when case histories are taken on any particular patient, some questions be asked which relate to the patient's general culture. In every community the doctor is in a favourable position to study his fellow men because he can ask any questions he likes in the name of Medicine. (Editorial 1967b: 41)

By the early 1970s the practical translation of this new 'cross-cultural outlook' on clinical medicine was well under way, and in 1971 gave rise to Mokhobo's temporarily definitive re-drafting of 'medical history-

taking among the Bantu tribes of South Africa'. Drawing upon Chamberlain and Ogilvie's (1967) demonstration that for some diseases in different stages of their development symptoms could be more important than signs, Mokhobo distinguished 'predominantly historical diagnoses' (e.g. angina, peptic ulcer, vascular insufficiency), and disorders where 'physical findings may be all important' (e.g. meningitis, malignant disease). Because 'many African patients exhibit a pattern of attitudes born of ... traditional influences' inscribed in 'Bantu medical practice', doctors unaware of the illness meanings created by these attitudes were liable to confuse the relative importance of symptoms and signs. Where thirty years earlier the African patient's utterances were a hindrance to accurate apprehension of the pathology, in this new approach the patient's story was central:

The Bantu patient ... may exasperate the doctor by explaining every one of his symptoms. [But] this self-analysis and diagnosis is, however, a priceless account to the doctor ... The manner in which the patient tells his story, his timed emphasis, all furnish information which may otherwise be hard to come by. (Mokhobo 1971: 112)

Such information was, however, apparent only to the doctor primed in understanding the cultural meanings attached to specific organs and symptoms, and 'a patient's psychological and cultural outlook must provide the mirror through which the clinical picture is viewed' (Mokhobo 1971: 112). This was provided by a compendium of 'tribal terminology' relating to various classes of disorder, a perceptual grid that enabled doctors to recognize how within indigenous African systems of diagnosis and healing 'Priorities of symptoms and signs have a complex but interesting treatment. A patient with gonorrhoea will give undue prominence to backache and not mention penile discharge, the reason being that the damage may have been inflicted on the kidney, which is an important organ of potency and masculinity' (Mokhobo 1971: 112).

Mokhobo's realignment of the relationship between signs and symptoms and his observation that traditional African healers saw these as nodal (rather than focal) points in a network of feelings and social relationships suggested an entire complex of semantic needs that for doctors under the earlier regime had not existed. Consequently, Barker (1971) could argue:

Your Zulu goes to the medicine man because our understanding is too small. We have failed to answer his unspoken question, we have not helped him at a level where our help is seen to *be* help ... If we learn anything

from this 'reversion' (as we so hatefully style it) to the medicine man, it is that physical healing is not considered enough in Zulu society ... Our Zulu patients do not just ask the ordinary question 'how?' – which we are expert at answering with our detailed knowledge of microbiology and biochemistry – but they also ask a more metaphysical 'why?' We, of course, most often do not realize that we are being asked the question at all, and almost never do we attempt to answer it. (Barker 1971: 559)

Indirectly through the intermediary of the African traditional healer, the gaze of the Bantu clinic had thus begun to engage with a new problem: that of the socio-cultural matrix which informed the African patient's view of illness and attitudes to western medicine.

The consequence of this was a bifurcation in the discourse of the clinic. On the one hand, recognition of the traditional healer's influence over the African's experience of illness encouraged research devoted to the scrutiny of traditional healing practices and illness beliefs. On the other hand, recognition of the African patient as a feeling person with psycho-social needs demanded a reorientation on the part of western doctors to accommodate these in the clinical context. This bifurcation formulated a new object of clinical knowledge – the African as a dichotomous patient produced at the confluence of western and traditional practices – who would remain a central figure in the eye of clinical medicine until the 1990s.

A dichotomous patient The old regime's triangulation method had linked signs and symptoms to locate the pathology in a unitary body. Conscripting of the traditional healer into the diagnostic and therapeutic process overlaid this with a triangulation involving the pathology, the doctor and the traditional healer. Signs and symptoms were still important, but their significance now lay in revealing how the disease pattern reflected the play of traditional healing, as did a 1972 study correlating pathology in rural Africans with 'religion', 'education', 'witch-doctor attendance' and 'the wearing of shoes' (Edginton et al. 1972: 969). Now that illness was interdependent with the fabric of traditional illness beliefs, Watts could in 1972 conceive of illness reactions among urban Africans as a sequence of 'separate steps' (such as visiting a hospital, consulting an 'inyanga', and sacrificing a goat), with an 'average' African patient taking '2,5 steps'. Because these steps invariably led between western and traditional practices, the doctor should always 'obtain insight into the traditional world-views and practices of their typical patients and ... how ... to modify patients' attitudes and behaviour when this is essential' (Watts 1980: 591).

Affirming an African patient that was the intersection of a triangular

relationship between it and the western and traditional practices now isolated for clinical surveillance, Ingle (1973) argued that 'it is axiomatic to start where people are and with what they believe' (Ingle 1973: 333), while Jansen's (1973) *The Doctor-Patient Relationship in an African Tribal Society* probed 'Bomvanaland' to explore the meaning of physical contact and the use of instruments during the examination of rural Africans:

Taking the medical history, the doctor communicates with his patient in his role of interviewer and presents himself as the one who must ask before knowing. As soon as he takes the role of examiner, he has a less dependent position towards his patient. In stead [sic] of standing in front of the patient with empty hands, now as examiner he operates with several kinds of instruments: stethoscope, reflexhammer [sic], sphygmomanometer, etc. No doubt this contributes to the status of the white doctor. When the examination is extended to the taking of X-ray films, the prestige of the doctor reaches its peak in the eyes of the patient. This modern apparatus contributes highly to the image of a powerful man who has mysterious methods to 'see' the diseased parts inside the body. The Bomvana call the X-ray the *u-Gesi*, a term used both for electrical instruments and for electrical light. (Jansen 1973: 109)

By 1974, Barker could castigate western doctors for having 'been blind for so long that almost none of us know what this Black patient is thinking' (Barker 1974: 34), while writers such as Manganyi (1974), Mgobozi (1974), Mutwa (1974) and Ngubane (1977) elevated African medical traditions to the status of a systematically structured cosmology that was one side of a culturally relativistic coin. African 'traditions and customs' (Gumede 1974) were now a barrier to the advancement of medicine only when despised and neglected, whereas if incorporated into clinical care they were valuable diagnostic and therapeutic tools: 'Unless we see Africans as they see themselves in disease not only as the western doctor sees them, these cultural traditional practices will continue to block development. Yet with better understanding they could be utilised to act as catalysts in promoting change' (Gumede 1974: 35).

In producing the African as a dichotomous patient whose emotional needs were met by traditional practices while western medicine treated only the body, a self-reflexive element entered the gaze of the Bantu clinic to problematize its failure in this regard. In 1975 Stott asked: 'Do we identify our patient's needs?' Drawing upon Rogerian psychotherapeutic principles, he advocated procedures for doctors in cross-cultural clinical encounters to monitor how their own attitudes and communicative tendencies might block rapport, and hear beyond what

the patient said to the subjectivity that these words might conceal. For what the patient said was now only one aspect of the patient's view, and in certain cases might 'be no more than an excuse to see and assess the doctor', or a method of entering the surgery as a prelude to revealing 'something ... difficult to verbalise' (Stott 1975: 33). In effect, the roles of patient and doctor were now reversible, demanding that just as doctors be comfortable assessing the patient, so should they accept it when 'the patient becomes judge/assessor' (Stott 1975: 34).

This recursive analysis by which clinical medicine problematized its own role in relation to the African patient extended well beyond individual clinical encounters to embrace the whole discipline, and in 1978 *The Leech* devoted an edition to 'The Role and Place of the Traditional Medicine Man and "Witchdoctor" in African Health Care'. Where nineteen years earlier Gelfand's (1947) evaluation of 'witchcraft and medicine' as 'enemies to the sick African's peace of mind' (Gelfand 1947: 4) reflected general opinion, it could now be said of the doctor who devalued traditional healing that he 'is certainly entitled to his opinion, but it is important to remember that there is more than one way of throwing the bones' (Dick and Murray 1978: 312). In place of the old medicine as an absolute technology, was now a 'western medicine ... [with] its own cultural relativity', which made it possible both to see the traditional healer and transform this practitioner from a threat to African clinical care into 'the best person to assist' the western doctor (Dick and Murray 1978: 312).

A flurry of work from here into the late 1980s extended the cross-cultural clinical gaze to solidify the African patient as the simultaneous product of western and traditional medicine. For some, this reflected the all-determining influence of culture and acculturation (e.g. Cheetam and Griffiths 1982; De Villiers 1985; Farrand 1984); for others the possibility of an agentic patient whose choice of healer was determined by income and access to health care (e.g. Boonzaier 1985; Buchanan et al. 1979; Heap 1985); and for others a template by which western doctors could reproduce in clinical practice the function of the traditional healer by answering the questions 'Why am I ill?' and 'Who made me ill?' (Daynes and Msengi 1979). Perhaps epitomizing this was Segal and Ou Tim's (1979) work on 'the witchdoctor and the bowel'. This integrated the ideas of urbanization, choice of healer and traditional healing to argue for a system that could draw 'the traditional practitioner into the structure of the health services' (Segal and Ou Tim 1979: 310), both to police any possible harmful practices (e.g. Buchanan and Cane 1976; Kiernan 1978), and confirm the role of 'psychologist, psychiatrist, marriage counsellor and healer' in which 'the vast majority

of Blacks believe in and consult the witchdoctor' (Segal and Ou Tim 1979: 310).

The 'quest for wholeness' and a subjective patient

The analyses that produced the relationship between clinical medicine, the African patient, and the traditional healer reconfigured the boundaries of the clinical encounter. For pathological medicine these had been restricted to the gaze of a solitary doctor and the isolated body of a single patient. Acknowledgement of the interrelationship between symptoms and feelings had brought the patient's immediate relationships to family, society and culture into the consulting room, but only as adjuncts to a process over which the doctor retained control through astute monitoring of the relationship between doctor, witch doctor and patient. By 1990, however, even the idea of the 'doctor-patient relationship' was an inadequate code for construing the psychological and socio-cultural forces at play, as the Bantu clinic began to fade under the close attention of sociologists, psychologists and anthropologists.

Thus, while somewhat paradoxically offering itself as a text devoted to 'whole-person care', *Clinical Health Psychology: A Behavioural Medicine Perspective* (Schlebusch 1990) argued for the untenability of distinguishing separate experiential realms for doctor and patient. Instead, the doctor, the patient, the disease, the illness and all interactions between them were now perceptually defined punctuations within an 'energy system ... seen as a collection of parts secured by some type of interaction or interdependence':

[E]ach person is comprised of systems which in turn are part of bigger external systems: while individuals are composed of molecules, cells and organs, they belong to families, communities, cultures, nature and the world. The biological, psychological and social structures of each individual are affected by other levels of system and *vice versa*. (Schlebusch 1990: 14-15)

Because it was the perceptual configuration of the observer rather than the object of observation that was now the crucial determinant of the clinical encounter, the patient's subjectivity could emerge as a focal object of clinical concern. Drawing on Eisenberg and Kleinman (1981), and McHugh and Vallis' (1986) work on 'illness behaviour', this 'biopsychosocial' model constructed the patient as suffering not only from disease but also 'illness':

A subjective, psychological and social experience which is therefore open to interpretation by both patients and the society in which they live, and

may in fact occur in the absence of disease ... It has idiosyncratic elements and is oriented towards problems of existence and coping so that its measurement ... must be orientated towards the viewpoint of the patient. (Schlebusch 1990: 41)

Some sixty years after the African patient first entered the Bantu clinic as a passive corporeal container of pathology, the codes of medical perception had mutated to invert the relative importance of what was seen and what was heard. Then, all that was heard was that which assisted the eye to see since disease was coterminous with the body; now illness could not be separated from the viewpoint of the patient since what was said was the illness.

Accordingly, Simon (1988) could argue that in 'ignoring' the patient's view bio-medicine was 'mechanistic' and, alongside analyses that explained African disease and the distribution of health care from a Marxist framework, authoritarian: 'The medical practitioner and the political economist are alike: both diagnose from a position of authority and control without much knowledge of what it is the patient or subject sees and experiences, wants and desires' (Simon 1988: 11). To counter this, it was now important that the doctor engage in 'the study of patients' perceptions and how they act on these' (Simon 1988: 182). Similarly, Heap and Ramphele (1991) characterized the earlier analysis of the clinic and traditional healer as 'essentially a debate among professionals based on their perceptions'; criticized it for failing to obtain 'any significant input from the "patients" who are the objects of their concerns'; and invited the reader to contemplate precisely these subjectivities as they shaped 'perceptions of illness and sickness' among African hostel dwellers (Heap and Ramphele 1991: 117-20).

'The quest for wholeness' (Heap and Ramphele 1991) informing these approaches to ascertaining the patients's view thus concealed in its concern with freeing what was previously trapped the more pervasive disciplinary operation of contemporary clinical perception. For they create the possibility of evaluating as 'reductionistic' (Rogers 1992: 5) and as 'illogically and deleteriously' dividing of the patient (Schlebusch 1990: 14), all methods of clinical medicine that produce anything less than the 'whole person', to thereby invent precisely the 'whole' and subjective patient they claim to have discovered.

Bodies and voices

The changes traced here in the discourse of the Bantu clinic reflect a shift from the tangible yet silent and passive body, to a loquacious and

subjectified 'whole person'. As a manifestation of power, how is this change to be understood?

From the Marxist and liberal-humanist view of sovereign power that in the 1970s began constituting the entire enterprise of South African medicine as a dehumanizing regime (see Dowling 1973; Medical Association of South Africa 1974), thoughts are freely spoken unless forcibly suppressed. The failure of clinical medicine until the 1980s to elicit 'the patient's view' and see the African patient only as a passive container of pathology is from this perspective evidence for a repressive regime in which the vociferous African was an immanent danger to be forcefully silenced. But in the Foucauldian schema silence is less a marker of repression than of discipline at play in the capillary complex of relationships uniting dominator, dominated and liberator. For, in this system,

There is no binary division to be made between what one says and what one does not say ... Silence itself – the thing one declines to say or is forbidden to name, the discretion that is required between different speakers – is less the absolute limit of discourse, the other side from which it is separated by a strict boundary, than an element that functions alongside the things said, with them and in relation to them. (Foucault 1979: 27)

The absence from secular clinical discourse until the 1930s, and the reconfirmation from then until 1960 of the African patient as a mute body in the Bantu clinic, cannot be simplistically regarded as evidence for the stifling power of oppression. Similarly, the 1960s' appearance of a speaking patient whose feelings were increasingly counted in the clinical procedure is not to be seen merely as the eventual liberation of an African voice for so long barred from speech. Rather, this arc from silence to speech maps no more than the functioning of a productive power which at certain points manufactures silence and at others a provocation to discourse. For far from unique to African genealogy of clinical perception, an equivalent sequence from the mute body of the passive patient to the loquacious voice of the 'whole person' is apparent in the discourse of the British clinic (Armstrong 1982, 1984).

These convergences notwithstanding, it is true that the African patient had to wait some ninety years longer than its European counterpart to possess a 'Bantu anatomy' equivalent to Gray's, and some twenty years longer to be heard as a subjective being. It is also true that the utility of Bantu anatomy as an object by which the apartheid state in part found its conditions of possibility meant it would deliquesce as the discourse of liberal-humanism arose in the 1980s to invent the universal body and authentic person it claimed to 'liberate'.

The social science challenge that medicine engage with the authen-

ticity of suffering in the words of the sick is therefore only a shift in disciplinary emphasis from the technology of seeing to that of hearing. For the tactical effect of this challenge is to install the confession, through which the most confidential ideas of everyone are amplified to audibility and lifted into socio-medical space as devices of disciplinary subjectification.

Notes

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1. Reviewers in 1944 of 'this pioneer attempt at filling the breach which has so long hampered South African medicine' (N.V.S. and P.K. 1944: 37) were critical of the generalizations made concerning disease distribution across the continent, but unequivocal in their support of its chapters on the patient and the examination, stating that 'the book is essentially clinical and should be in the hands of every medical practitioner dealing with the Bantu' (N.V.S. and P.K. 1944: 39).

2. This new concern with language and communication was operationalized in Campbell and Lugg's *Handbook to Aid in the Treatment of Zulu Patients* (1958). This was produced for use by European doctors in the non-European wards of Durban's King Edward VIII Hospital, and provided a compendium of instructions and diagnostic questions in English and their Zulu equivalents concerning everything from the routine physical examination, invasive instrumental investigations such as 'sigmoidoscopy', advice on home sanitation and the importance of always carrying a 'pass book'.