

- Figlio, Karl, 'How does Illness Mediate Social Relations? Workmen's Compensation and Medico-Legal Practices, 1890–1940', in P. Wright and A. Treacher (eds), *The Problem of Medical Knowledge: Examining the Social Construction of Medicine*. (Edinburgh: Edinburgh University Press, 1982).
- Fishback, Price V., 'Liability Roles and Accident Prevention in the Workplace: Empirical Evidence from the Early Twentieth Century,' *Journal of Legal Studies* (1987), 56: 305–328.
- Gillespie, Richard, 'Industrial Fatigue and the Discipline of Physiology,' in Gerald L. Geison (ed.), *Physiology in the American Context, 1850–1940*. (Bethesda, MD: American Physiological Society, 1987).
- Gillespie, Richard, 'Accounting for Lead Poisoning: The Medical Politics of Occupational Health and Safety,' *Social History* (1990), 15: 303–331.
- Gray, Robert, 'Medical Men, Industrial Labour and the State in Britain, 1830–1950,' *Social History* (1991), 16: 19–43.
- Harrison, Barbara, *Not Only the Dangerous Trades?: Women's Work and Health in Britain, 1880–1914*. (London: Taylor & Francis, 1996).
- Ineson, Antonia, 'Science, Technology, Medicine, Welfare and the Labour Process: Women Munition Workers in the First World War,' University of Sussex, M. Phil. dissertation, 1981.
- Jones, Helen, 'Employers' Welfare Schemes and Industrial Relations in Inter-war Britain,' *Business History* (1983), 25: 61–75.
- Kippen, Sandra, 'The Social and Political Meaning of the Silent Epidemic of Miners' Phthisis, Bendigo 1860–1960', *Social Science and Medicine* (1995), 41: 491–499.
- Labisch, Alfons, 'Doctors, Workers and the Scientific Cosmology of the Industrial World: The Social Construction of "Health" and the "Homo Hygienicus",' *Journal of Contemporary History* (1985), 20: 599–635.
- Martin, Emily, *Flexible Bodies: Tracking Immunity in American Culture — From the Days of Polio to the Age of AIDS*. (Boston: Beacon Press, 1994).
- McIvor, A.J., 'Manual Work, Technology, and Industrial Health, 1918–39,' *Medical History* (1987), 31: 160–189.
- Navarro, Vicente, 'Work, Ideology, and Science: The Case of Medicine,' *Social Science and Medicine* (1980), 14: 191–205.
- Rabinbach, Anson, *The Human Motor: Energy, Fatigue, and the Origins of Modernity*. (New York: Basic Books, 1990).
- Rabinbach, Anson, 'Social Knowledge, Social Risk, and the Politics of Industrial Accidents in Germany and France,' in Dietrich Rueschmeyer and Theda Skocpol (eds), *States, Social Knowledge, and the Origins of Modern Social Policies*. (Princeton, NJ: Princeton University Press, 1996).
- Rosner, David and Markowitz, Gerald, *Deadly Dust: Silicosis and the Politics of Occupational Disease in Twentieth-Century America*. (Princeton: Princeton University Press, 1991).
- Rosner, David and Markowitz, Gerald (eds), *Dying for Work: Workers' Safety and Health in Twentieth-Century America*. (Bloomington: Indiana University Press, 1987).
- Sellers, Christopher C., *Hazards of the Job: From Industrial Disease to Environmental Health Science*. (Chapel Hill: University of North Carolina Press, 1997).
- Stabile, Donald R., 'The Du Pont Experiments in Scientific Management: Efficiency and Safety, 1911–1919,' *Business History Review* (1987), 61: 365–386.
- Waldron, H.A., 'Occupational Health During the Second World War: Hope Deferred or Hope Abandoned?', *Medical History* (1997), 41: 197–212.
- Weindling, Paul (ed.), *The Social History of Occupational Health*. (London: Croom Helm, 1985).
- Wise, M. Norton and Smith, Crosbie, 'Work and Waste: Political Economy and Natural Philosophy in 19th Century Britain', parts 1–3, *History of Science* (1989), 27: 263–301, 391–449; (1990) 28: 221–261.

The Third-World Body

WARWICK ANDERSON

A specific 'Third-World body' does not exist; nor can we invent it. Representations of the native body or colonial body abound in popular and technical literatures of the nineteenth and early-twentieth centuries, but with formal decolonisation these bodies are necessarily, if imperfectly, disguised in an emergent discourse on global citizenship. One can find discussions of the Third-World citizen, an identity perhaps precarious and faulty, but any appearance of bodily difference in this governmental discourse implies its failure. The Third World is, in effect, a project for overcoming corporeal specificity and stigma through modernization. In providing an enunciatory position, Third-Worldism exacts a dematerialization, a transcendence of the native body — thus the Third World can afford to have a distinctive literature but not a distinctive body. And when bodily specificity resurfaces, as it does in representing famine or diseases like AIDS, it is usually taken to reveal the would-be expressive citizen as no more than a recidivist dirty native. In regaining such a body, one can lose the world.

My concern here is limited to Western biomedical representations of Asian and African bodies in the twentieth century. I will try to treat some recent work in the history of colonial medicine as though it could be read as a critical history of constitutions of the body. In so doing, I want to suggest a loose framework for understanding discourses of colonial embodiment and post-colonial citizenship. My argument is basically that colonial medicine was a socio-spatial discourse that becomes reframed as a discourse on human rights and governmentality during the twentieth century. Medical experts continued to represent African and Asian bodies as diseased, lazy, and grotesque — as symbolic inversions of a European social body — but they also began to hold out the hope that a colonial body subject to strict protocols of personal and domestic hygiene might reform itself, or rather, that an individual might use these technologies of self-care to acquire a generic citizenship. No longer just objects to provoke European self-satisfaction, the colonized were offered Western subject positions and a role in global capitalism. And yet the apparently hygienic citizens produced in these new medical discourses always teetered on the brink of atavism: they were always dressed natives, recovering natives, their full citizenship necessarily incomplete or deferred. Economic failure,

THE THIRD-WORLD BODY

incurable disease and the lack of God's grace could all mark their lasting abjection. Post-colonial identity has been produced as a bipolar disorder, with the natural repeatedly overbalancing the cultural, the savage overwhelming the civilized, the black overshadowing the white. The figure of the insubordinate native body thus keeps on staging its return with the help of the IMF, global media, and Mother Teresa.

These flexible typologies of native bodies illuminate a relentlessly dichotomizing European imagination more than they reveal the experience of any colonial body. Asians and Africans were not palimpsests awaiting European inscription; one can find as much resistance and indifference to protocols of hygiene as acceptance. The body may have been the target of colonial discourse but there is little evidence of a direct hit. Recent ethnographies of health and disease suggest that if changes in clothing, housing, diet, toilet, and manners occasionally reshaped subjectivities, they did so in ambiguous or unpredictable ways. Accordingly, I am not so concerned with the truth of these cultural inscriptions on the body as with the political effects of their supposed truth. It is the politics of colonial bodily control and discipline, and not phenomenology or biology, that interests me here. Of course the history of Asian and African bodies should be more than the history of European perception of them, or European imprinting on them, but these imperial ideologies continue to provide the more salient landmarks for that larger history.

Is there anything distinctively colonial or Third World about this story? Surely the same processes of stereotyping, the same marking and remaking of social boundaries, the same rituals of bodily purification, took place in Europe and North America during this period, the targets there women and the poor as much as other races. David Arnold, following Michel Foucault, has pointed out that there is a "sense in which all modern medicine is engaged in a colonizing process."¹ And yet, given the obvious gender and class analogies, I believe we can still detect some distinctive features of the colonial poetics of pollution. The authors of imperial medical discourses on embodiment found themselves peculiarly foreign and vulnerable, and therefore so much more anxious to assign marks of danger to others; in alien circumstances more is at stake in defining corporeal boundaries. Not surprisingly, the lines they drew, so rigid and yet so readily recast, traced more explicitly than in Europe the boundaries of race (even if this category could still presuppose a gender and a class). By the late-nineteenth century, the colonial consciences of man were thoroughly genealogical. They were also intimately connected with the expansion of the colonial state, a nexus which, as much as anything else, must have impressed on the local population the foreignness of this typologic discourse, at once more assertive than it had been domestically, and less hegemonic.

The history of a specifically colonial framing of the body is well disguised in conventional histories of twentieth-century medicine and imperialism. It is hard to detect any body in the glorious history of 'insect wars,' in tales of the triumph

of germ theory in the tropics, and, more recently, in the story of Western medicine's complicity with colonial expansion. No doubt these instrumentalist histories work well in their proper context, but they tell us little or nothing about representations of European and native embodiment. There are, of course, some exceptions. Arnold regards the body (in late-nineteenth-century India) as a site of contestation between the colonized and the colonizers, and not simply a colonial construction or a biological given. In a recent series of articles, Ann Laura Stoler has examined early-twentieth-century medical inscriptions on the bodies of subordinate colonizers in Southeast Asia. Lenore Manderson and Nancy Hunt have traced the development of an interest in the reform of bodily habits of mothers and children in diverse colonial settings. In Randall Packard's account of discourses on African susceptibility to tuberculosis, we can find the construction of the body of the maladjusted, detribalized African. John and Jean Comaroff discuss the "interplay of natural facts and semantic projects,"² including Western medicine, in the cultural production of the African body in the early-twentieth century. Megan Vaughan has provided us with an even more detailed survey of the framing of the African social body in later biomedical discourses. All of these studies have been produced in the last decade or so; most of them are inspired by the interest of anthropologists such as Pierre Bourdieu in embodied cultural practices, and by the work of Michel Foucault on the construction of the modern biopolitical subject. In what follows, I draw principally on these texts and my own work to suggest a tentative, and perhaps provocative, framework for a history of colonial and post-colonial bodies.

EUROPEANS, NATIVES, AND THE SOCIAL BODY

In the late-nineteenth century, colonial public health was still primarily a social-spatial discourse; it had governmental implications, but its logic was generally more repressive than disciplinary. By this I mean that colonial public health officers set out to control collectives in a pathogenic landscape; if they happened to reshape an individual's sense of self this was an unanticipated benefit.

That Europeans characterized non-Europeans as primitive, lazy, lascivious, profigate, superstitious, untrustworthy, grotesque and irresolute has become, through the work of Philip Curtin and Edward Said among others, a commonplace of colonial history. "My body was given back to me sprawled out, distorted, recolored," writes Frantz Fanon. "The negro is an animal, the negro is bad, the negro is mean, the negro is ugly...."³ This sort of disparagement generally meant that the features assigned to native races were exactly those traits that Europeans believed they had themselves transcended: their perceptions of others described what they imagined had been expunged from their own identity. Sander Gilman has found a psychoanalytic explanation for the generation of these stereotypes; others, including Nancy Stepan, point to more obvious political and economic reasons for classifying different groups of people as inferior, even sub-human. Whatever the cause, there

can be little doubt that the various classifications of races, and various orderings of these human types (always, though, with Europeans on top), informed most Western medical theory in the late-nineteenth century. Typologies of race provided Europeans with compelling generalizations to account for an otherwise bewildering array of biological and cultural differences. These ready-made categories allowed colonial emissaries to write homogeneity onto foreign populations and onto themselves. Every society, and especially their own, could be regarded as an organic whole, a social body with distinctive characteristics.

These racial types could be ambiguously gendered and sexualized. Of course, European males tended to present themselves as epitomes of self-possessed masculinity, according to the current conventions of this historically variable trait, but native races were always something else, or rather, someone else. What this was could vary by time and region. Gilman, in considering representations of Africans, argues that the black female in the nineteenth century comes to serve as the icon for her sexualized race. Other scholars have claimed that the colonized, especially Asians, are generally represented in the passive feminine; still others emphasize the popularity of tropes of perverse masculinity, applied particularly to African males and occasionally to Asian females. The common feature of all these attributions is the location in another race of abnormality, excess and danger. Boundaries between the colonizer and the colonized necessarily would be marked by hygiene and sexual control.

In attempting to define races, European scientists were at the same time structuring (and restructuring) the relations of humans to their environment and to one another. Each race was located securely in its ancestral realm and derived its distinctive biological and cultural forms from long residence in a distinctive environment. The bounding and typing of physical space thus went together with the production of definite types of racial bodies: to a great extent, then, racial determinism in the late-nineteenth century was an environmental determinism. In defining the tropical environment, for example, scientists were specifying the character of all the living organisms, including humans, that had struggled for existence there, or that God in his economic wisdom had placed there. The tropics are particularly apposite as an example. Philip Curtin and others have observed that by the eighteenth century, Europeans had created a myth of tropical redundancy, contrasting a primitive exuberance with the staid gardens of Europe, and furthermore, they followed Montesquieu in suggesting an intimate relationship between this tropical vegetation, tropical bodies, and tropical mentality. In a sense, these doctrines were no more than specifications of revived Hippocratic environmentalist theory. The tropical races — improvident, relaxed, disordered — seemed to exist in the easiest of natural conditions. In a region of apparently female plenitude, no wonder that feminization of the local inhabitants was the default drive of colonial discourse, and that the torrid zones implied not just heat but passion too. Darwin and Wallace could seize on the homologies of race and

environment to suggest that humans in the tropics had evaded those selection pressures that had in the distant past produced the hardier, go-ahead, European races. An over-nurturing mother nature had allowed her human charges to remain louche, irresolute and primitive. In an evolutionary schema tropical bodies bore the marks of a difference that was as much temporal as physical.

With the effort to make Europe global, the most pressing question was what would become of a race transplanted from its native soil and climate. Europeans feared they might either evolve into local types, so that acclimatization might mean pigmentation and worse, or they would degenerate and die out, like the exotic tropical organisms then languishing in chilly northern zoological gardens. The principle that a race was best fitted to resist the diseases of its ancestral realm — and, as a corollary, was especially vulnerable to ailments encountered in a foreign land — was a remarkably resilient element in late-nineteenth-century biomedical understandings of disease susceptibility. An enormous amount of colonial epidemiological research and diverse clinical experience could be built into this framework of meaning, as to a large extent it did not matter to such predispositionist theories whether the cause of the ailment was miasma or microbe. Theories of racial immunity thus constructed European imperialism as a medical conundrum: foreign places evidently could be taken as white dominions yet they were no place for a white man. During the first decades of the twentieth century, medical scientists sought first to reformulate and then to resolve this impediment to European expansion, so that responsible citizens might be projected onto any part of the globe and flourish in spite of their bodies.

Although white bodies in the colonies were deemed especially vulnerable, not all of them were degenerating or recuperating from illness, nor were all natives in robust good health. Racial bodies could be ambiguously diseased, or deemed prone to disease. While most Europeans continued to regard racial adaptation as the chief determinant of disease expression, they also appreciated the influence of other factors, including diet, character, energy, and the degree of exposure to pathogenic material. At the same time, with the consolidation of imperial control in the late-nineteenth century, and prompted by an interest in developing local labor, improved epidemiological surveillance was indicating that natives succumbed to disease at least as often as foreigners. Clearly racial resistance was less absolute than previously thought. Many public health officers were quick to attribute the newly recognized native liability to moral failings, for if the locals were acquiring diseases that their race had previously resisted, then they must surely have become very depraved indeed. After all, natives should have had a long process of adaptation on their side, unlike whites who got sick: disease among natives suggested a pathological race culture, while Europeans remained, usually, the innocent victims of migration. With germ theory, the increasingly evident disease burden of the locals, yet another reason for cultural self-satisfaction, soon also became a cause of intense somatic anxiety for Europeans.

DIRTY NATIVES AND HYGIENIC CITIZENS

At the beginning of the twentieth century, as colonial economies became better integrated into a global economy, native bodies were increasingly recognized not simply as the body of the other, but more importantly perhaps, as the body of the worker, or the body of the future worker's mother. These were bodies to be studied, surveyed, disciplined and, when necessary, reformed to ensure their efficiency as parts of the emerging world system.

In this context, bacteriology provided a new resource and rationalization for surveillance. From the 1890s, colonial public health officers had dedicated themselves to tracking down and isolating portable microbial pathogens. The transmission of these germs could be traced ever more efficiently and persuasively through local insect and human populations, so much so that during this period we see, in effect, an anthropomorphic mobilization of pathology. Disease was more likely to derive from other bodies, less likely to emanate from environmental filth. As a result, soon after it had become common knowledge that many native bodies were manifestly diseased, colonial medical scientists were able to reveal a more widespread, and hitherto disguised, disease carriage among even apparently 'healthy natives.' In native blood they found malarial parasites; in native stools they found enteric parasites; in their sputum, the germ of tuberculosis. 'Apparently healthy' native disease carriers were blamed for outbreaks of typhoid, cholera, and even plague. Being of a tropical race no longer conferred a likely immunity to tropical disease: more often, it could be taken as complicity in the transmission of local germs. Had not native races evolved with these pathogens and so developed a symbiotic relationship, a partial immunity to them? The native body was thus represented as a special physical reservoir for local disease organisms, a container that unhygienic racial custom and habit seemed ever to be filling to the brim. Previously, medical authorities had thought that bad native habits would simply overcome the local race's supposed resistance to local disease; now it seemed likely that unhygienic behavior could also turn many locals into embodied agents of disease, while remaining meretriciously healthy. (One might argue that this is a generalization to all diseases and all locals of long-standing fears of contracting venereal disease from native women.) Physical and cultural difference was never more congruent with the threat of disease.

Colonial health authorities initially concentrated on building barriers between deceptively diseased natives and vulnerable whites. Thus after 1900 the native body was often a segregated body. Systematic racial segregation, justified on sanitary grounds, became common in settler societies such as South Africa, and remained in place so long as it was consistent with local labor arrangements. New theories of disease etiology had inflamed fears of racial contact, but these were old fears and easily fueled. In any case, racial segregation in colonies of exploitation was less consistent with economic needs and was rarely enforced with the same vigor.

Instead, the more progressive and optimistic imperial powers, such as the United States in the Philippines, increasingly emphasized education and retraining of supposedly disease-dealing natives. Where segregation was not feasible, reculturation might be tried. As an appreciation of supposedly insidious cultural practices, especially those concerning defecation and eating, began to supplement the emerging biological understanding of disease transmission, colonial medicine, long modelled on the military campaign, rapidly assumed more the character of a world-wide evangelical movement with the goal of converting local peoples to the gospel of hygiene. (This was predicated on an emerging biomedical and anthropological consensus that culture could be freed from its biological shackles and independently historicized.) Strict enforcement of the rules of personal and domestic hygiene promised multiple benefits: local populations, less manifestly unwell, would be able to work more efficiently; less likely to carry disease organisms, they would present fewer dangers to foreigners. One can argue, then, that tropical medicine was principally a localized form of industrial hygiene, first for the colonizer, and then for the laboring colonized.

Beginning in the American empire, and later generalized by the efforts of the Rockefeller Foundation and the international health organizations of the inter-war period, public health authorities sought to ensure that colonial possessions were inhabited with what they regarded as propriety. Medical texts insistently contrasted the closed, ascetic body of the colonizer with the open, grotesque native body, the former typically in charge of a sterilized laboratory or clinic, the latter squatting in an unruly, promiscuous marketplace. In this medical poetics of pollution, the imagery of waste practices offered a potent means of organizing a teeming, threatening environment and society. The self-asserted bodily control of the colonizer symbolized political and social control, while the apparently 'promiscuous defecation' of the natives mocked and transgressed the firm, closed colonial boundaries.⁴ In constructing these symbolic inversions of the formal European body, colonial health officers justified their power to inspect and regulate the personal conduct and social life of the colonized. Faced with all this apparent danger and promiscuity, the only responsible course was to examine systematically the colonial population, to disinfect it, and to reform its customs and habits. Public health thus produced a space for the somatic disciplining of supposedly refractory natives: the colonizing process was represented more than ever as a civilizing process. As a result, the infantilization of the native had become as significant as any gendering.

During the twentieth century there has been a massive expansion in health education and publicity projects directed at 'normal' children and adults. Health services have issued regular bulletins, cartoons, and films to instruct local populations in personal hygiene, home cleanliness, the preparation of balanced meals, and the care of the sick; they have maintained exhibitions of sanitary model houses, sanitary methods of sewage disposal, and sanitary villages; they have sent photo-

graphs, parade floats and 'healthmobiles' to fairs and fiestas in order to illustrate modern methods of hygiene; and they have issued warnings about the poisonous nature of fecal matter, the evils of handling food, the dangers of spitting. New marketplaces built with hygienic concrete came to replace the old unwholesome plazas; the promiscuous fiesta turned into the martial Clean-Up Week; and toilets sprouted everywhere, even inside houses. Through the schools, children learnt of the perils of raw vegetables, impure water, poorly ventilated houses, a sedentary way of life, and deformed posture; each child had to bathe daily, wear shoes, wash his hands before eating, and never touch the food. In the Philippines, health experts urged every seventh-grade boy to learn how to construct a toilet. Megan Vaughan has observed that in Africa from the 1930s a missionary discourse on mother and child health was secularized and applied more widely. Zimbabweans in the 1940s learnt that they required Lifebuoy soap and other cosmetic or hygienic products. Nutritional research and advice also became more common during this period, with the expectation that environmental changes could elevate, and so normalize, the race.

In a sense, colonial health officers in the twentieth century had staged a binary opposition between themselves (European or Europeanized) and the typical native, and then asked the colonized to resolve this typological difference through personal conversion, so demonstrating that their failings could be overcome, that they could, in effect, transcend tainted embodiment and primitive culture. The prevention of disease transmission was linked intimately with training in civic responsibility, with the production of self-possessed, disciplined colonial (and proto-national) subjects. From the 1930s, colonial public health is argued increasingly in terms of 'human rights,' and not just as the social control of dangerous bodies. Accordingly, histories of the international health services, which document the emergence of this discourse, can be read as disembodying modernization stories. The framing of international health promotion and the development of governmentality had come to resemble two transparencies laid over each other.

Perhaps one of the more telling examples of this superimposition is the Gandhian association of national independence with individual self-government, a "micro-physics of self-discipline."⁵ For Gandhi, who described the body as a bag of filth, the reform of personal hygiene was linked through the logic of modern public health to a scheme for national self-purification. Taking colonial asceticism seriously, he argued for a celibate nation of manly, self-controlled citizens with generic bodies of steel. We thus have the paradox of a decolonization, an entry into the Third World, predicated on the colonizing, or the overcoming, of one's own body.

Disciplined, purified Third-World citizens make themselves available as labor power and commodities. The rise of an international trade in organs attests as much to the cultural production of generic, interchangeable body parts as it does to advances in surgery and immunosuppression. Desperately ill members of a globalized middle class can pay for the kidneys of poor Indian villagers or choose

more widely from the organs of executed Chinese prisoners. Even so, surgical purification rituals may still be subverted by the polluting agents of hepatitis and AIDS, diseases that limit participation in the global body market. Thus the return of the native body still interferes with the circulation of generic body parts. The generic body may be a global commodity, but the production of such commodities has not yet become fully standardized in the Third World.

CONCLUSION: AIDS AND THE RETURN OF THE NATIVE

The primitive and the abject are never fully expelled from the body in this medical discourse of governmentality: the erstwhile modern citizen is represented as having constantly to abstract himself from nativism. In this sense the destabilizing tropics in the twentieth century have been internalized in all of us. Since Freud, Europeans have recognized the savage within; and since Fanon, natives have formally been given a superego. In this shift to interiority, the governmental self seems to operate as an unstable, conflicted duality of body and mind, nature and culture. If colonialism often presupposed a monist self, implicated in a racialized poetics of pollution, in the 'post-colonial' world this social dichotomy has been internalized, so that we may appear to progress, in representation if not experience, from a polarized social hybrid to an equally polarized individual hybrid, a microcosm of the political order.

But not all hybrids are equal, and not all individuals appeared equal to discipline. In particular, medical reports of the colonial civilizing process often seem no more than a litany of its failures. Randall Packard has described the invention of the problem of the "dressed native," which "placed responsibility for the apparent physical and moral failings of urban Africans, reflected in high mortality rates, alcoholism, family separations and crime, on African inexperience with the conditions of urban industrial life"⁶ — a colonial version of blaming the victims. Like all transitional figures, the modernized native, as matter out of place, caused classificatory uncertainty and anxiety. Cultural reform had been linked symbiotically to bodily reform, and both were endlessly deferred, so that the colonized would remain precariously in remission rather than cured, and always on the verge of responsible self-government, yet never quite there. In the Third World, that place of liminal modernities, the primitive seemed always on the point of expunging the civilized from subjectivity. The locals were represented inseparably as both recovering natives and incipient citizens.

In accounting for disease in the Third World, first-world commentators have often summoned up these images of the scarcely civilized, recalling the atavistic passion and depravity of the native type. (Of course the real atavism is more in their own vocabulary than in any actual behavior.) The naturalization of social suffering is vividly illustrated in the standard famine-and-disease shots on television and in the newspapers. In the construction of 'African AIDS' notions of promiscuity, ignorance, superstition, flawed maternal instincts, and natural associations

with monkeys, have all returned. Africans are again represented in popular texts and in medical reports as intractable primitives scattered over the sick continent. Through this discourse on the failure of governmentality, "the child-like 'primitive' is immediately identified as a sexual adult and as a sexually active child."⁷ Paula Treichler has pointed out an homogenization of the grotesque and licentious in images of AIDS in Africa, which renders Africans recognizable in the West, but unfamiliar to themselves.⁸ Cindy Patton also emphasizes a displacement in 'African AIDS' of the political and social onto the sexual and racial; anthropological efforts to identify distinctive African sexual practices thus have 'resexualized' African bodies. The implication, then, of much of the medical discourse on AIDS in Africa is that native sexuality "requires rapid reorganization into bourgeois families"⁹ — demands, in effect, a recolonization of the continent by NGOs. At the same time, Nancy Scheper-Hughes has argued that, if anything, some natives have been regarded as rather too well dressed, too civilized, in policy discourses on AIDS in Africa. She believes that the emphasis on education and voluntarism, with an assumption of individual human rights, apparently so characteristic of the public health response to AIDS in the Third World, has put people not included in this 'androcentric' governmental discourse (such as women and children) at special risk.¹⁰ Despite their apparent differences, all of these analyses share a conviction that the metaphors we use to explain 'African AIDS' will have material effects in Africa.

Biomedical discourses concerning the Third World continue to oscillate between these poles of representation, between the generically hygienic body of modern human rights discourse and the dangerously primitive racialized body of typological thinking, between the contained body of the responsible citizen and the excessive body of the promiscuous native, between the civilized and the sexualized, even though the site of this oscillation has moved inwards to describe a relentlessly dichotomous model of subjectivity. The safely hybrid subject is made repeatedly to enact the same old colonial encounters. And so, in the Third World, the native just keeps on returning as an excitingly assailable target of disciplinary discourses.

REFERENCES

I would like to thank Peter Phipps for research assistance and comments on this essay. Research for this essay was supported in part by a Special Initiatives Grant of the Faculty of Arts at the University of Melbourne.

1. David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India*. (Berkeley: University of California Press, 1993), p. 9.
2. John and Jean Comaroff, *Ethnography and the Historical Imagination*. (Boulder: Westview, 1992), p. 71.
3. Frantz Fanon, *Black Skin, White Masks*, trans. Charles Lam Markmann. (New York: Grove Press, 1967), p. 113.
4. Warwick Anderson, 'Excremental colonialism: public health and the poetics of pollution,' *Critical Inquiry* (1995), 21: 640–669.

5. Joseph S. Alter, 'Gandhi's body, Gandhi's truth: non-violence and the bio-moral imperative of public health,' *Journal of Asian Studies* (1996), 55: 301–322, p. 304.
6. Packard Randall, 'The "healthy reserve" and the "dressed native": discourses on black health and the language of legitimation in South Africa,' *American Ethnologist* (1989), 16: 686–703, p. 687.
7. Simon Watney, 'Missionary positions: AIDS, "Africa" and race,' in Russell Ferguson *et al.* (eds), *Out There: Marginalization and Contemporary Cultures*. (Cambridge, MA: MIT Press, 1990), pp. 89–103, p. 98.
8. Paula Treichler, 'AIDS and HIV infection in the Third World: a First World chronicle,' in Barbara Kruger and Phil Mariani (eds), *Remaking History*. (Seattle: Bay Press, 1989), pp. 31–86.
9. Cindy Patton, 'From nation to family: containing "African AIDS,"' in Andrew Parker *et al.* (eds), *Nationalisms and Sexualities*. (New York: Routledge, 1992), pp. 218–34, p. 225.
10. Nancy Scheper-Hughes, 'AIDS and the social body,' *Social Science and Medicine* (1994), 19: 991–1003.

FURTHER READING

- Burke, Timothy, *Lifebuoy Men, Lux Women: Commodification, Consumption, and Cleanliness in Modern Zimbabwe*. (Durham NC: Duke University Press, 1996).
- Butchart, Alexander, *The Anatomy of Power: European Constructions of the African Body*. (London: Zed Books, 1998).
- Cooper, Frederick and Stoler, Ann Laura (eds), *Tensions of Empire: Colonial Cultures in a Bourgeois World*, (Berkeley: University of California Press, 1997).
- Curtin, Philip, *The Image of Africa: British Ideas and Action, 1780–1850*, 2 vols. (Madison: University of Wisconsin Press, 1964).
- Farmer, Paul, *AIDS and Accusation: Haiti and the Geography of Blame*. (Berkeley: University of California Press, 1992).
- Gilman, Sander, *Difference and Pathology: Stereotypes of Sexuality, Race, and Madness*. (Ithaca: Cornell University Press, 1985).
- Lambek, Michael, and Strathern, Andrew (eds), *Bodies and Persons: Comparative Perspectives from Africa and Melanesia*. (Cambridge: Cambridge University Press, 1998).
- Manderson, Lenore, *Sickness and the State: Health and Illness in Colonial Malaya, 1870–1940*. (Cambridge: Cambridge University Press, 1996).
- Packard, Randall, *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa*. (Berkeley: University of California Press, 1989).
- Radin, Margaret Jane, *Contested Commodities*. (Cambridge MA: Harvard University Press, 1996).
- Stepan, Nancy, *The Idea of Race in Science: Great Britain 1800–1960*. (Hamden CT: Archon Press, 1982).
- Vaughan, Megan, *Curing Their Ills: Colonial Power and African Illness*. (Stanford: Stanford University Press, 1991).