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Chapter 10

From Colonial to Global: Visuals and the Historiography of Body Government beyond Europe

Jean-Paul Gaudillière

Introduction

Farm to Pharmacy is a documentary shot in 2011 in India, in the state of Orissa. Four images illustrate its plea for the modernization of traditional uses of medicinal plants. The first one is shot in a greenhouse where women formerly engaged in collecting plants in the wild now cultivate some of them, following the advice of an evidently non-tribal expert from *Sambanth* (Figure 10.1a). The second one shows the administration of a herbal formula against stomach pain by a *vaidya*, a practitioner of Ayurveda, who belongs to the teams of healers the NGO has organized to improve access to care (Figure 10.1b). The third image shows the mechanical processing of stems in order to prepare a whole plant extract in good manufacturing conditions, evidenced by the masks and caps the workers wear (Figure 10.1c). The fourth shot illustrates the economic success of the project with a store where the community sells the products of its cooperative production unit and brings in new income that is ‘equitably distributed’ (Figure 10.1d).



a



b



c



d

Figure 10. 1: Stills taken from *Farm to Pharmacy*—a: shifting the supply of medicinal plants from collection to cultivation under the supervision of state experts, 02:57 minutes; b: turning plants mixtures into stabilized and ready to use combinations, 05:07 minutes; c: processing plant parts in a controlled, quick, and germ-free way, 03:50 minutes; d: selling the community made remedies in drugstores, 05:50 minutes.

The film promotes the activities of a local NGO called *Sambanth* whose employees work with tribal communities in order to advance a ‘holistic, participatory, sustainable’ model for the revitalization of local health traditions based on modernized uses of medicinal plants. The

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film thus portrays remote and impoverished people whose ancient knowledge and plant resources are vanishing, now benefiting from the expertise of the NGO to build a non-biomedical system of care and pharmaceutical production.

Farm to Pharmacy is therefore a misnomer as the title refers only to the final status of medicinal plants. A better name could run as *From Healing Traditions to Industrial Holistic Remedies* since the film links two patterns of transformation of the local knowledge: its integration in a formal arrangement articulating healing and pharmacy on the one hand; and the modernization of its practices to sell remedies while conserving the botanical resources, on the other. *Farm to Pharmacy* thus conveys a strong visual argument about bodies (tribal, sick, expert), care (holistic, traditional, ethno-pharmaceutical), and capital (manufacturing, commercial, human).

Body, capital, and screens: the association of these three words, the editors of this book explain, points to the role that modern visual mass media played in the transition from a national bio-political public health paradigm at the beginning of the nineteenth century characterized by collective bodies, a work force and labour society to societal forms of the late twentieth century where normality for better and healthier individual life is increasingly shaped by market forces and fundamentalism.¹

This is not an isolated claim. Over the past twenty years, many authors in the history and/or the social studies of science and medicine have argued for similar grand transformations of the relationship between biology, human bodies, and the social fabric—even though they have not addressed the question of media production. To take one well-known example, Nikolas Rose's book *The Politics of Life Itself*, insists on the idea that a new regime of discourses and practices characterizes contemporary body politics with the new centrality given to the government of (biological) risk.² Rose argues that this regime has roots in three major trends: the molecularization of biomedicine; the subjectification of biopolitics (the new identities of patients/users/consumers becoming responsible for their health, i.e. managers of their personal risks); and the convergence of health and economics through the development of bio-capital, risk prevention markets and globalization.

Rose's approach owes much to Michel Foucault's famous lectures on 'Naissance de la biopolitique' at the Collège de France, which—since their publication—have puzzled historians of health.³ In spite of their title Foucault did not delve into the government of populations but focused rather on the advent on neo-liberalism, German hordoliberal economics, and what he perceived to be major shifts in the relationship between the state and the market. Biopolitics was however not far away. The new politico-economic order Foucault was struggling to describe was linked in many ways to another transition he had explored previously, namely the diversification of biopolitics into a regime of *discipline* and sovereignty on the one hand, and a regime of *regulation*, insurance, and probabilistic control of conducts on the other.

By pointing to the new roles of genetics, its molecularization, and its links to the government of risks, and labelling his new regime a 'politics of life itself', Rose echoed Foucault's approach of regulation and pointed to the intimate relationship neo-liberalism was creating between markets, bodies, and their self-regulation. However, while Foucault insisted on the synchronic relationship between disciplinary and regulatory technologies, Rose critically introduced a diachronic dimension in line with the core hypothesis of *Body, Capital and Screens*.

To a perspective already centred on body practices, *Body, Capital and Screens* adds a strong interest in the social life of markets AND the media, that is, a strong interest in the

¹ Introduction to this volume, p. 1.

² Rose, *Politics of Life Itself*.

³ Foucault, *Naissance de la biopolitique*.

relationship between the actions of economic actors, consumers, companies, marketers, or regulatory institutions alike, on the one hand, and the production of visual discourses, on the other. The following chapter considers the dialectics of body government from the perspective of the recent historiography of health outside Europe, and its *decentring* of the Eurocentric gaze on modernity. We argue that this historiography, with its diverse approaches to the changing relationship between knowledge, economies, and government, raises the question of how we—as historians—can approach the neo-liberal management of health with its cortege of market logic, performance, individual responsibility and choices, and thus open venues for enhanced dialogue with the history of visuals.

Three Historiographies of Health beyond Europe: Empires, Subalterns, World

If anything can count as a massive, unambiguous and all too often highly destructive form of disciplinary government of health and bodies, it is the nineteenth- and twentieth-century form of globalization associated with the making of the French, British, German, Dutch, and Belgian empires in Africa and Asia. Healthy bodies, markets, and empires then came together around several patterns of action that recent historiography has sought to disentangle. The first mode of existence of colonial medicine was around the problems Europeans were facing when they moved to the ‘tropics’: their lack of adaptation to the places and their inhabitants, including their inability to resist fevers, to adjust the local food, and to support the heat and humidity.⁴

The existence of a common—humoral—episteme shared by the Hippocratic European tradition and the elite medicines of Asia initially reinforced the idea that indigenous and European bodies were not essentially different and therefore that Europeans had much to learn and to borrow from the practitioners of non-Western corpuses of medical knowledge. This radically changed during the last decades of the nineteenth century in a context of increased competition between European powers, struggle for the natural resources that a booming industry was consuming, and mounting racialization of social groups at home and abroad, in conjunction with major changes in European medical knowledge (the rise of both clinical medicine and the laboratory). The result was a profound divergence rooted in different ontologies of bodies and diseases, and the defence of a hegemonic status for Western medicine.

The second mode of existence of colonial medicine emerged out of different concerns regarding the colonial subjects and their value for the empire. Serious concerns for the fate of indigenous bodies emerged around the First World War I. What resulted was the invention of *mise en valeur* and development that, in practical terms, remained limited to efforts to maintain a healthy labour force and to instil (often through forcible means) a work ethic in the colonized as the backbone of rational colonial exploitation. More broadly, it did nevertheless also still mean the modernization of the so-called primitive or barbaric worlds and their inhabitants through the construction of new cities, the education of colonial subjects, the recovery of infertile soil, and the establishment of new institutions that sought to ‘civilize’ according to the ideals of republican and/or democratic virtue.⁵ The policies designed to control sleeping sickness in Africa from the 1930s onward exemplify the importance that vertical programmes then gained in the practice of colonial management.⁶ Inoculation campaigns aimed at eradication through the treatment of people identified as carriers of parasites. They relied on the creation of devoted squads visiting villages, and on the standardization of

⁴ Harrison, *Public Health in British India*; Harrison, *Medicine in an Age*; Pati and Harrison, *Health, Medicine and Empire*.

⁵ Keller, *Colonial Madness*.

⁶ Lachenal, *Le médicament*.

quick microscopic detection that could be applied with a few instruments and at large scale. Last but not least, they involved rudimentary assessment of treatment productivity based on the ratio between staff involved and inoculations performed.

In order to better characterize this historiography of imperial health, it is useful to take into account the issues historians have focused on, the actors they study, the forms of capital and forms of knowledge they consider, and the nature of the sources they have tapped (Table 10.1). The imperial historiography of the government of bodies then appears as the history of a disciplinary order aiming at the exploitation of both nature and subaltern people. Its main actors were the colonial agents, that is, settlers, military men, physicians, missionaries, and administrators. The capital involved came primarily from the metropolis. It was industrial in the sense that it focused on the resources—raw materials as well as food—needed ‘at home’ in order to pursue the process of industrialization, and it was extractive in nature. Priority health problems were those affecting populations as such, that is, epidemics and reproductive health with the consequence that colonial or tropical medicine as a corpus of knowledge was a combination of bacteriology and vital statistics. Finally, the sources explored were almost exclusively colonial archives, which were read ‘against the grain’ as Arlette Farge once put it.

	Imperial historiography	Subaltern historiography	World historiography
Issues	Exploitation (labour, nature), disciplinary order	Hegemony, resistance, nationalism, hybridization	Circulations, geopolitics, development, neo-liberalism
Main actors	Military, colonial administration and experts, settlers	Peasants, workers, indigenous elite	NGOs, enterprises, U.N. system, nation-states
Form of capital	Imperial, industrial, and extractive	Native, land & commerce	Multinational, financial, and industrial
Priority health problems	Epidemics, reproductive health	Epidemics, famine, and malnutrition	Emerging and neglected epidemics, reproduction
Forms of knowledge	Bacteriology, health statistics	Traditional medicine, healing & rituals	Economics, epidemiology
Sources	Colonial archives	Local and private records, oral history, ethnography	International archives

Table 10.1 Health, bodies and government beyond Europe: Three modes of historical analysis.

In the 1980s and 1990s, a new historiography emerged outside Europe, revisiting colonial and postcolonial times from the vantage point of the native subjects. What may be called the subaltern historiography of health has indeed revealed the extent to which modernization outside Europe was grounded in non-Western views and practices that were cultural as well as material. This is powerfully illustrated by the work of the Indian *Subaltern Studies Collective*, which emerged as an attempt to renew the nationalist and Marxist historiography of colonial India, using Gramsci’s concept of hegemony expanded along different lines during the two decades of its existence. The collective’s first wave of studies focused on the ways in which *subalterns*, that is, peasants, women, low caste, or workers experienced and resisted the colonial order, in congruence with or opposition to a mounting nationalist movement.⁷ This was very much in line with the kind of history that emerged in the 1960s and 1970s under the label ‘history from below’. During the late 1990s and early 2000s, the publication of Partha Chatterjee’s *The Nation and its Fragments* and Dipesh Chakrabarty’s

⁷ Chakrabarty, *Rethinking*.

Provincializing Europe signalled an important shift as these books no longer documented and analysed the life of the subalterns but returned to elite debates on modernity and its Western origins.⁸ Alternative modernity was thus important in Chakrabarty's critique of Western historiography, highlighting two responses, two modes of 'provincializing Europe': the writing of history of—and from—non-Western perspectives; and a revision of Europe's own history revealing its roots in—and connections with—non-European historical trajectories.

The history of health and body politics was far from being marginal in this *decentring*. It provided a unique nexus for analysing the status of Western knowledge, its putative incommensurability with 'Indian' counterparts, the tensions undermining colonial politics, or the defence and transformation of (reinvented or rediscovered) traditional practices. David Arnold's *Colonizing the Body* is one of the most influential books originating in the subaltern collective. His analyses of British sanitary interventions in India contrast with the imperial historiography not in terms of objects and issues (the book is, for instance, still focused on the management of infectious diseases, i.e. cholera, smallpox, or plague) but rather in the way he posits colonial policies in relation to the reactions and views of the people they targeted.⁹

Smallpox management is an especially interesting example since the *longue durée* of vaccination policies in Europe and India makes the gradual divergence between colonial and native medical systems visible. Before 1830, when *orientalism* nurtured a real interest in the practices of Ayurveda or Unani physicians, vaccination against smallpox was a terrain of encounter, a practice perceived as analogous to the local (Indian) custom of transferring pustules from affected to healthy bodies in order to appease the goddess *Sitala* and restore the balance of bodily humours. After the failed Indian uprising of 1857, in a context of racialization of British perceptions, smallpox vaccination lost its resonances with the local medical culture. It became a policy broadly enforced through inoculators recruited and trained by colonial medical officers while elite families were courted to display their acceptance of the procedure. Smallpox vaccination was thus turned into a symbol of both the superiority of Western scientific medicine and its incommensurability with natives' medical cultures.

The legacy of the subalterns in the history of health beyond Europe has been quite significant. Recent works are however less concerned with hegemony and the colonization of bodies, than interested in the complex encounters and circulations that participated in the making of alternative medical modernity. In the case of India two aspects of the latter have been investigated: 1) the transformation of 'traditional' practices to constitute medical systems perceived as decisive elements of an Indian national heritage; 2) the adaptation to—and borrowing of—European practices by Indian physicians who accordingly created hybrid medical cultures. Guy Attewell's exploration of the world of Ayurveda and Unani doctors in the late nineteenth and early twentieth centuries is a good example of the first.¹⁰ In *Nationalizing the Body*, Projit Mukharji in turn offers a very convincing history of hybridization based on the practices of Bengali *daktari*, practitioners with or without qualifications who built a boundary medical world for a modern and unified India through the appropriation of biomedicine and its combination with indigenous knowledge.¹¹ Having collected texts and pamphlets written by Bengali doctors, most of them conserved in private hands, Mukharji traces the making of a nationalized body that emerged in parallel with Arnold's colonized body. He thus brings to the fore a different mode of subaltern agency than the latter's combination of hegemony, resistance, and compromise.

How can we summarize the shifts this subaltern historiography has performed? In terms of issues (Table 10.1), hegemony replaced exploitation, bringing in not only the idea

⁸ Chakrabarty, *Provincializing Europe*; Chatterjee, *Nation and its Fragments*.

⁹ Arnold, *Colonizing the Body*.

¹⁰ Attewell, *Refiguring Unani Tibb*.

¹¹ Mukharji, *Nationalizing the Body*.

that power is based on acceptance of the dominant discourses and practices, but also the fundamental idea that the subjects of power are not passive. The agency of subjects led not only to patterns of resistance but also to appropriation. This shift of the issues to consider is the consequence of choosing the subalterns as the main actors. The history is now written on the basis of what the 'natives' thought. This implies that the forms of capital considered are less metropolitan than local, more strongly associated with land and commerce than with industrial production. The shift evidently required the mobilization of sources alternative to the colonial records, in order to capture these voices in a more direct manner than reading institutional archives against the grain. These sources are not only less formal written documents generally found in private collections but also ethnographies and interviews documenting the memories and legacies of the past. This has brought history into a deeper dialogue with other social sciences, and primarily with anthropology. In terms of content, the subaltern historiography of health is concerned not only with the management of epidemics (although they still figure prominently in the published works), but also with issues that, though barely discussed by the colonial administration, became major challenges for the local modernizers and the nationalists, for instance, famines and nutrition, changes in family life, or what was perceived as a 'weakening' of the colonized bodies. In parallel, the centrality of alternative modernization implies that the sources of knowledge taken into account are 'hybrid', with a critical role of reinvented and secularized medical traditions. Subaltern studies thus oscillate between 'history from below', with the emphasis initially placed on restoring the voices of the subjected, and therefore the religious dimension of healing powers, on the one hand, and on the other hand capturing 'alternative modernity' with its unique dialectics of adaptation and opposition that grounded the rise of nationalism as the main framework to secularize and improve the practices of the local elite rather than the orally-transmitted traditions of local healers.

In parallel with the rise of a subaltern historiography, another genre gained visibility in the 1990s: world history. The first issue of the *Journal of World History* thus explained:

During the past two or three decades [...] historians have become increasingly aware of some inherent limitations in historical writing focused on national communities. [...] Many powerful historical forces simply do not respect national or even cultural boundary lines, but work their effects instead on a regional, continental, or global scale. To name but a few, these forces include population movements, economic fluctuations, climatic changes, transfers of technology, the spread of infectious and contagious diseases, imperial expansion, long-distance trade, and the spread of religious faiths, ideas, and ideals. In their efforts to analyze [...] these forces, scholars have generated a body of literature increasingly recognized as world history—historical analysis undertaken not from the viewpoint of national states, but rather from that of the global community.¹²

Since then initiatives have been multiple, and 'global history', 'global studies', and 'history of globalization' have become reference terms for a specific mode of historiography insisting not only on the necessity of bringing together the histories of Europe and those of the rest of the world, but also on historicizing globalization, on the long-term existence of world-wide circulations and exchanges, and therefore on the multiple ways in which national or imperial histories have been connected.

Health is a highly relevant topic in this respect, not only because of the *longue durée* of multiple connections between Europe, the Americas, Africa, and Asia that the historical

¹² Bentley, 'New Forum', p. iii–iv.

trajectory of cinchona, quinine, and malaria treatments over three centuries powerfully illustrates, but also because *global health* has—in the past thirty years—become a field in itself with its actors, institutions, programmes, and forms of knowledge that have a problematic relationship with previous patterns of interventions beyond the scale of one nation or one state.

The global is however a problematic category and entry point. The historian Frederick Cooper thus writes in *Colonialism in Question* about the tyranny of the global.¹³ Here the tyranny comes in three forms: first, the global is an integral part of several hegemonic discourses (those of the financial economy, of the despaired progressive politicians, and of the postmodern ‘dance of flows and fragments’ that academics have taken up); second, the global entails a dictate of ‘presentism’ such that history begins with contemporary issues, and is therefore barely compatible with approaches of the past for its own sake; third, the global is always the global of a situated someone and it often goes with ungrounded generalization and the pretence of seeing from above and from nowhere, a syndrome shared with discourses of modernization.

World history has nonetheless addressed the challenge of inscribing the recent and transnational transformations of health in the past. The most visible strategy has been to write an international history focusing on the life of organizations, networks, enterprises, and individuals whose mere existence and field of action extend beyond national boundaries. Development aid, intergovernmental initiatives, and the U.N. system established after World War II are in this respect paramount. The current historiography tends to see their policies in deep continuity with those of colonial empires.

A good example is provided by the post-war malaria campaigns. Marcos Cueto argues that the malaria campaigns were typical outcomes of the controversial logic of a vertical programme favoured by a U.S.-dominated international public health. They relied on a ‘technological dream’ focusing on a quick and single fix (DDT).¹⁴ They equally built on strong confidence in short-term quasi-military interventions, led by foreign experts who mobilized operational research rather than clinical knowledge, and did not consider that specific knowledge of the local and social factors contributing to the transmission of the disease was needed. In addition, the malaria campaigns surfaced in the 1950s as Cold War attempts to use social investments to contain communism. Their termination was not only the result of mounting technical difficulties but also of a shifting imperial agenda with the 1960s’ growing commitment of U.S. bilateral aid to population control. Finally, even if these campaigns were inter-governmental ventures grounded in the ‘cooperation’ between nation-states, they continued the colonial policies of development based on technology transfer and medicalization designed by Northern experts.

Geopolitics is thus central in the narrative. In 2006, Theodore Brown, Marcos Cueto, and Elizabeth Fee published a seminal article entitled ‘The World Health Organization and the Transition from International to Global Public Health’.¹⁵ The change is seen as a political phenomenon to be placed in a large-scale context of geo-political tensions, development strategies, and rivalry between international organizations. On that basis, global health appears as a response by prominent actors in international health—from U.S. universities to WHO—crafted in order to adapt a rapidly changing international order as a consequence of: a) neoliberal reforms (the debt crises and structural adjustments, the creation of WTO, the globalization of intellectual property rights); and b) the fall of the Soviet bloc. This context helps to understand why the strong 1980s pleas against the Alma-Ata strategy and for the

¹³ Cooper, *Colonialism in Question*.

¹⁴ Cueto, *Cold War*.

¹⁵ Brown and others, ‘World Health Organization’.

return of vertical programmes were backed by new actors like the World Bank or corporate philanthropy and became so powerful.

Not all global histories align on this pattern. Environmental history has, for instance, led to very different work when addressing industrial pollution or climate change with stronger interests in local sites and practices.¹⁶ When it comes to health, the global has de facto favoured macro-analysis placing geopolitics at the centre. The result (Table 10.1) is a historiography based on international archives, which focuses on geopolitics and the general issues of development targets and strategies, neoliberal governance, and public health policies. This has resulted in strong interest in the life of institutions, ranging from U.N. organizations to NGOs and nation-states' administrative bodies, with insights into the processes of expertise, decision-making and implementation. Within such a perspective, post-war programmes figure prominently with important work done on the control of epidemics (malaria, smallpox), population control, and maternal/infant care. The forms of knowledge explored thus concern in the first place epidemiology, economics, and operational research. The forms of capital involved are almost exclusively those related to the rise of multinational enterprises: industrial capital and, for the most recent period and to a lesser extent, financial capital.

With all its richness of analysis and documentation, the global history of health thus seems to fall into the traps Frederick Cooper points out in his essay: running the risk of leaving out the practices of intervention, their contextual and localized nature, and the problematic generalization that accompanies the contemporary fabric of the global.¹⁷ Thinking about alternatives, Cooper insists on the importance of circulation and transnational/connected histories showing that globalizations have been and are multiple. The historian should therefore target objects and issues that are more than local and less than global, looking at regional flows, networks and diasporas, as well as territories, boundaries, and hindered moves. In order to open up the gaze and circumvent the asymmetry of archives and sources, she should combine history and anthropology.¹⁸

Films and the Historiography of Health Government from the Colonial to the Global

Having put in place these different genres of historiography and the need for a stronger engagement between history and anthropology, it is striking that visual media appear to be missing, apart maybe from a significant but essentially illustrative use of photography. The question is therefore whether this situation is a matter of 'conjuncture', originating in historians' habits as they developed for a couple of decades, or 'structural', that is, linked to the very nature of films and their conditions of production, which result in their absence or their inappropriate status for a decentred history of health outside Europe and North America. In other words, could there be a visual colonial, subaltern, or world history of health and bodies, or is a visual rendering of the trilogy as a consequence of differing visual mediascapes in the global South impossible?

Mere absence is clearly not the issue. The inventory of actors involved in the production of films about health and bodies in the twentieth century includes colonial offices, industrial firms, the Health Organization of the League of Nations, and later the WHO, international health societies, multinational pharmaceutical firms, the World Bank, experts commissioned to visit developing countries, or anthropologists conducting individual as well as collective projects. Their genres are equally varied, from 'raw' documents in a research

¹⁶ Isenberg, *Oxford Handbook*.

¹⁷ Cooper, *Colonialism in Question*.

¹⁸ For a similar plea in the context of the history of health and medicine, see Harrison, 'Global Perspective'.

corpus to the personal souvenirs of prominent individuals, not to mention the impressive production of educational material.

Up to a recent period, however, most of this production (with the possible exception of untapped but most likely rare private sources) was not only institutional but Euro-American in origins and viewpoints. Just like imperial or global institutional archives, such films may be analysed against the grain and provide critical insights in the perspective and contradictions associated with ‘external’ interventions on the health and lives of others.

Films of the colonial period have often been associated with the presentation/promotion of specific campaigns or interventions. Directly echoing the events described by Guillaume Lachenal and mentioned above, *La mission Jamot au Cameroun*, was produced in 1939 by the Pasteur Institute, using footage shot during the sleeping sickness control mission that Dr. Jamot led in the region of Ayos during the years 1926–1932.

The strong visual identity of the film first originates in the display of tropical medicine with its three mandatory dimensions: epidemiology, microbiology, and pathology. Epidemiological knowledge surfaces in two different ways: the first one, at the beginning of the film, is the abstract display of numbers of deaths and affected persons (visible on screen and spoken by a voice over) and maps; the second one is the sequence showing intervening teams establishing neighbourhood maps of incidence. Microbiology is however the iconic ingredient of the performance: sequence after sequence include microscopes and technicians, slides preparation and colouring, inserts of (often drawn) images of cells and parasites, and close-ups of mosquitos.

The strong presence of pathology and clinical knowledge is the most specific aspect of *La mission Jamot*, with a long presentation of the training of African nurses (all males) received at the project’s headquarters located in Ayos’ hospital where, as the commentary explains, hundreds of affected patients gathered. Images of long lines waiting for examination thus precede a teaching sequence where typical ‘cases’ of the different clinical syndromes associated with sleeping sickness are ‘presented’. Moving images are ‘doing the job’ with no commentary. They reveal how the disease affects movements, how bodily control is lost with trembling patients, tics, falls, and finally paralysed patients (*grabataires*). Clinical knowledge is to a large extent a matter of diagnosis. In such a colonial context, it takes a rather specific form since it is always practiced on collectives, that is, as screening. In *La mission Jamot*, diagnosis is based both on physical and on microscopic examinations. Sampling for blood and lymph fluid are presented as central tasks with long shots of lymph and dorsal punctures practiced on lines of waiting natives, while a commentary insists on how the procedures have become routine (‘two million performed in three years’) and demanded by the people.

This ‘*medicine de masse*’ resonates with an aesthetics of mass campaigning. *La mission Jamot* powerfully presents the administrative and organizational nature of colonial medical ventures. It is not only that patients are almost exclusively forming lines; the interventions themselves are carried out by squads and mobiles units. These operate according to a well-defined division of labour and in parallel, just like work on assembly lines. Microscopy is practiced in groups (Figure 10.2), lymph node examination is a matter of a few standardized gestures, and record keeping and delivery of medical cards is finally done by a specialized ‘writer nurse’ (*écrivain*) at the bottom end of the operating line. Unsurprisingly, performance is the outcome. It comes in the film with a final sequence bringing back the maps and numbers from the introduction but focusing on figures like the number of microscopic slides examined and the estimated number of lives saved (100,000) during the three years of the mission.

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Figure 10.2 The mass diagnosis of sleeping sickness: microscopes and natives agents working in line, still taken from *La Mission Jamot*, 03:39 minutes.

This penultimate sequence however fuses into the image of a laughing *Docteur Jamot*, happy to have 'awakened' Cameroun from its sleep. *La mission Jamot* is therefore also about this contrast of white characters and black bodies. Throughout the film the difference and the hierarchy is visually made and remade: white doctors are carried along the way when squads move; with the exception of the trained African nurses, black bodies are barely clothed and are never subjects of the action. The apex of this display of disciplinary management of subaltern bodies is the practice of marking the results of diagnoses (T for trypanosomiasis) and the treatment dosage (ciphers of quantity to be inoculated) with white paint on patients' breast before they are sent to the *écrivain* (Figure 10.3).



Figure 10.3 Black bodies, white doctors: painting the diagnosis' result and the treatment's dosage, still taken from *La Mission Jamot*, 14:47 minutes.

The relatively vast corpus of post-war malaria films could be used to explore the continuities of this visual culture of health campaigns before and after independence. Malaria films systematically mobilized the same elements: images of microscopes, working technicians, and microscopic shots to speak about the vectors and their cycle; long sequences of visiting teams at work, that is, sampling, examining bodies, and spraying DDT; technical artefacts ranging from DDT containers to spraying equipment and trucks; African bodies in lines or observing the intervening units.¹⁹

As the post-war era unfolded, significant shifts in modes of representation emerged. They challenged any scenario equating colonial project, nation-state-based development programmes, and global health interventions in the name of outside, techno-centred, and disciplinary interventions. Research remains to be conducted in a careful and systematic way but one can—as working hypothesis—consider two periods of significant shifts regarding both health programmes and body representations. The first one is post-war decolonization and the advent of development as a major paradigm used to think and organize *inter-national* government of health; the second one is the late twentieth century and the neo-liberal reshuffling.

Decolonization and the development era brought in major shifts, starting with the coming to the fore of ‘Third World’ nation-states, which were capable of producing their own documentaries advocating for the alliance of nationalism, technology, and progress. But they also conveyed a new understanding of what the hegemony of the North might mean, with a vision of ‘cooperation’ under the umbrella of techno-commercial partnerships to free the world from diseases and organize a rational handling of populations and labour forces. These films thus highlight the transition from colonial *mise en valeur* to another regime of modernization and unequal North-South relationship central to the historiography of global health: development.

A good example of the pervading presence of development aid in the postcolonial government of bodies is a documentary called *India's War against Malaria* from 1958, commissioned from the Ministry of Health. It includes all the items of colonial tropical medicine campaigns, but differs from *La mission Jamot* in three ways: first, it originates with a state initiative and shows a *national* venture organized by the newly independent Indian state from the beginning to the end, even if the cooperation with the United States is acknowledged in the first sequence but only as supplier of massive amounts of DDT; second, it speaks not about Western (European) science but about the training of an *Indian* force which masters all the technologies of interventions, from microscopy to village surveys and training; third, medical (clinical) knowledge is replaced with technologies in the most direct and physical sense of the term: the film barely shows villagers and focuses on operators handling laboratory instruments, trucks, DDT powder, and spraying material, and advocates one single control procedure, mosquito eradication, thus leaving out all questions of diagnosis and treatment.

Germany has a special place in this story as it faced a major challenge: redeeming itself from Nazi racism and its colonial forerunners. *Brücken der Hilfe* (Bridges of help) produced in 1952 by the chemical-pharmaceutical company Bayer on the control of malaria may serve as an example as it radically departs from the standard malaria documentary in two decisive ways.

The first one is the total absence of white people in non-European locations. Even if it follows malaria campaigning in Ghana, *Brücken der Hilfe* shows no white expert. All the qualified actors visible in the film are African technicians, nurses, and doctors who conduct surveys, look in the microscope, examine the bodies of their fellow country women,

¹⁹ For further discussion of this visual culture, see Bonah, ‘Health Crusades’; Bonah, ‘In the Service’.

distribute drugs, and spray insecticide. Moreover, the lines and assemblages of (black) bodies typical of *La mission Jamot* have disappeared, to be replaced by individuals, families, or informal gathering of village communities. The one exception relates to the conduct of blood sampling for diagnostic purposes, which shows a line of smiling women and children associated with an off-screen voice commenting on the fact that these women have no anxiety and were not 'kommandiert' (commanded), but willing to participate in what is claimed to be a performance. *Brücken der Hilfe* thus constructs an image of health intervention as a local venture, organized by Africans for Africans, who willingly consent because they share the project's common goals. Spraying for mosquitoes is shown less as a procedural success and more as an interaction: while the visiting team prepares the insecticide solution they are observed by the village assembly and the editing alternates between shots of working technicians and smiling, curious inhabitants. Similarly, in contrast to the rash entry of spraying units into houses, displayed in most malaria films, here the indoor spraying sequence begins with a conversation between the team and the family whose house is treated (Figure 10.4).



Figure 10.4 *Brücken-der-Hilfe*-Spreading units negotiating access to a village house with its inhabitants, still taken from *Brücken der Hilfe*, 11:26 minutes.

If eradication is a matter of African mobilization for the benefit of Africans, where is development aid? This is the second level of discontinuity operating in *Brücken der Hilfe*: it reveals how a new division of labour is emerging with Africans acting and Europeans knowing. As producer of the documentary, Bayer figures prominently in its narrative. Bayer and its factories (there is a long panoramic of the Leverkusen plants viewed from the sky at the end of the film) appear not as a *commanding* centre but as a *research* centre and a (tacitly market-oriented) supplier of chemical substances. In the middle of the film, a long sequence (five minutes out of a total of thirteen) narrates the history of anti-malarial drug research in Bayer's in-house laboratories. The oral listing of chemicals, trials, and effects is superimposed on images of laboratory work and production machinery that depict only chemistry and its power: technicians filling glass vessels, filtering preparations, holding measurement apparatuses, working on the background of a library of chemicals with several dozen storage vessels (Figure 10.5), testing the effects on chickens. It ends with a miracle new insecticide powder flowing out of machines.



Figure 10.5 The search for molecules as main contribution of Bayer to development aid, still taken from *Brücken der Hilfe*, 06:31 minutes.

This promotion of pharmaceutical R&D leads up to the concluding narrative when—after the presentation of spraying teams—the film comes back to Germany in order to discuss the problem of the increasing resistance of mosquitos. Far from shying away from the problem or advocating the then common response in terms of speed and enlarged mobilization to achieve eradication, the commentary—again, against the background of chemical laboratory images—highlights the ability of the German chemical industry to search for new molecules that will be tested and employed in the South in order to win the global race of ‘research versus resistance’. Beyond the colonial/development transition, *Brücken der Hilfe* thus points to continuities between development and the present imagery/imaginary of global health.

Given the scale of this institutional production of films, there is little doubt that imperial and world historiographies of health, bodies, and capital beyond Europe would benefit from a more decisive and systematic reliance on media sources and their historiography. The most difficult question our typology raises is however that of a possible subaltern historiography since the latter centres on voices that are much more difficult to hear in a corpus produced almost exclusively by actors from the global North. However, one peculiar genre is equivalent to the anthropological sources subaltern historians have revisited and used, namely the small but significant production of ethnographic documentaries, which started in the interwar period and grew rapidly after the war.

Jean Rouch is in this respect an obligatory passage point. In *Les maîtres fous* shot in 1955 in Accra (Ghana), Rouch explored one of the many rituals of possession that he would later follow with his camera. Rouch insisted on the indispensability of images, not only to better capture the complexity of actions and the centrality of bodies and movements, but also as the only way to convey something of events that Western words and categories barely render.

The film starts with shots of Accra, one of the massive urban centres then growing in Africa (*‘une Babylone noire’* says the voice over), with images of streets, crowd assemblies and a long sequence displaying workers: carriers, smugglers, bottle boys, timber boys, gold mine workers, and ‘hygiene boys’ spraying insecticides (Figure 10.6). The intent is to show

the challenge the new urban order poses to all those who join it, coming from the northern rural areas. How to survive the noise, the agitation, the painful and harsh working conditions? The possession rituals are ingredients of the response Rouch is investigating, and the camera follows members of the *haouka* sect on their way to a distant plantation.



Figure 10.6 Modernization agents at work in Accra: the hygiene boy, still taken from *Les maitres fous*, 03:00 minutes.

The second and longest section of the film presents the possession ritual itself with its different phases: the presentation of new members, the public confession, the display of personalities acquired as an effect of being possessed by one of the *houakas* ('the gods of the city, of technology, of power, of "the force"', says the voice over) and finally the sacrifice and eating of a dog. Although the film was attacked for its display of hallucinated, 'crazy' Africans and the violence of some scenes, Rouch's images and commentary support a social science reading of the situation. Entering the plantation, the camera focuses on the artefacts used: pieces of cloth displayed as flags (*Union Jacks*), a termite nest painted in black and white (*the governor's palace*), pith helmets, wooden rifles, commanding scarfs, etc. The most revealing sequence is in that respect the shots showing the possessed men and their respective *haouka*—most of them military characters (a lieutenant, a corporal, a general, the governor himself) or linked to the masters' technology with an engine driver and Mrs. Lokotoro, the doctor's wife (Figure 10.7)—who enact protocols of inspection, parade, surveillance, conferences, or round-tables. The ceremony is mimicking the colonial order, combining mockery and appropriation of the white people's own rituals. In order to make this reading more convincing, Rouch even inserts a sequence of images of a British army corps in Ghana saluting the flag. The third section follows the participants of the ritual the next day, after they have returned to Accra and resumed their normal activities. Ironically, the leading *haoukas* are water works employees digging trenches in front of the local psychiatric hospital. The last comment of the voice over thus suggests that these men are such good workers because—with possession rituals—they have found 'a remedy not to become abnormal'; a remedy that European medicine neither has nor understands.



Figure 10.7 Mrs. Lokotoro, key character of the *haoukas*' possession ritual, still taken from *Les maîtres fous*, 14:45 minutes. [The subtitle says 'Mrs. Lokotoro makes fits and receives a woman dress'.](#)

Even if Mrs. Lokotoro, the doctor's wife, could be incorporated into a narrative of colonial government of health (and of its hijacking), the most important aspect of Rouch's cinema for our discussion is not its direct documentary value but the positioning it reveals. In a vein similar to postcolonial histories like Nancy Rose Hunt's recent work on health rituals, insurgencies, medicalization, and population management in Congo, for which she decisively uses oral stories, songs, rumours, and diaries, Rouch seeks to capture otherwise unrecorded voices, and oscillates between two registers of interpretation. The first one, which prevails throughout the commentary, is that of rationalization, with the idea that the members of the *haouka* sect have invented a form of moral resistance: mimicking the rituals of British rulers is at once a way to disempower them and to capture their symbolic power. From this perspective, possession is both foreign as a form and familiar as a process. It may be accounted for in the same way that the social sciences have secularized and read Christian rituals, and this preserves the view from outside that the voice over perfectly instantiates.

The second register of interpretation echoes the *Subaltern Studies Collective* warning that such rationalization can remain a master discourse since it dismisses the actors' own motives and explanations for their actions and turns the ritual into a symbolic event, denying the existence of *haoukas* and possession as such. When David Arnold discussed the indigenous ritual of smallpox transfer in colonial India, he argued that what was unacceptable in the British transformation of the practice into vaccination was its secularization, the erasing of all links with the goddess Sitala. Rouch tries to avoid this very same trap in the last scenes of the film when the commentary introduces a different reading of possession, speaking of a 'remedy' through which the colonized subjects confront the madness of living in Accra, can perform their duties as workers without losing their minds, and thereby gain agency. The *haoukas* are therefore not only real *for them* but they are real *for us* since they make possible something—a form of cure or a mode of socialization—that European societies have either lost or never found.

Les maîtres fous thus offers the same response to the problem of hegemony and its critical reading as the subaltern historiography does, namely balancing recording and retelling, to let *decentred* voices come to the fore. Such strategy might well have become

commonplace in ethnographic filming after World War II when the divorce with imperial anthropology was consumed. Rouch was however never fully satisfied with the commenting voice and he was also ready to let things go in a more profound way, rewriting scenarios with the performers he was studying, or handing the camera to them. This transfer of agency acquired institutional dimensions with the establishment of a film section within the new social science institute created in Niamey after independence, that Rouch directed and where a whole generation of Nigerian ethnographers and film-makers emerged.

Although a subaltern historiography of body capital in the period from the 1930s to the 1970s may tap into the corpus of ethnographic documentaries, it is important to point out the diversification of possible sources when production in the global South diversified from the early 1960s onwards. *Farm to Pharmacy* mentioned above, along with its promotion of a 'neo-traditional' vision of health, bodies, and capital, is not an isolated example. A history of global health and its relations to the neo-liberal mode of body government could thus rely on a palette of visual sources in addition to the documentaries that Northern players made to promote their new agenda of health for growth, risk management, sustainable development, and community participation.

Conclusion

Michel Foucault's famous lessons on the birth of biopolitics did not delve much into the government of populations but focused on the advent on neo-liberalism and what he perceived to be major shifts in the relationship between the state and the market. The new politico-economic order that Foucault sought to identify may be seen as the most recent step in the transition from a regime revolving around disciplines and sovereignty, to a regime of governmentality revolving around norms of conduct, regulation, and individuals' choices.

Echoing this distinction, this chapter has discussed the recently decentred historiography of the body and health practices, focusing on the ways in which writing a history of health government beyond Europe has shifted our understanding of the local and the global (and thereof the relationship between history and anthropology), the status of Western and non-Western health practices, and the dialectics between discipline and regulation. It thus distinguishes three modes of writing about bodies, health, and capital (Table 10.1): colonial history with its focus on empires, processes of diffusion from the centre to the periphery, and mass-campaigning; postcolonial and subaltern history, which seeks to 'provincialize' Europe through local stories of hegemony, resistance, and alternative modernity; and global history with its interest in geopolitics, international arenas, flows, and development.

Such a classificatory exercise is always schematic as it operates on the basis of a limited set of categories and does not do justice to the forms of historical writing that fail to match, or that blur, the neat arrangement of types. Typology is nonetheless helpful in: a) emphasizing the relative coherence of each mode of historiography, as the grid helps to reveal its strengths and blind spots, as well as its relationship to peculiar periods in the twentieth-century trajectory of health government; b) highlighting the benefits of new ways of articulating these three modes, and thus furthering our understanding of the critical role of neo-liberalism—including its limitations—in the contemporary dialectics of capital, bodies, and government.

Having put in place these different genres of historiography, it is striking that visual media barely play a role in their operations. The first plea of this chapter is therefore that a more decisive engagement with the history of visuals will greatly benefit our understanding of the changing relationship between capital, bodies, and government, beyond Europe. The perspective however raises the difficult issue of sources. Decentring implies access to sources beyond those produced by the 'big actors' of imperial, international, or global health. Up to a

recent period most of the production of films and visuals was not only institutional but Euro-American in origin and viewpoints. Such films provide critical insights into the perspective and contradictions associated with ‘external’ interventions on the health and lives of others. A subaltern historiography of body capital should however tap into alternative corpuses, which may include not only ethnographic films but also the multiple visuals produced in the global South from the early 1960s onward. Since the latter production has rarely figured in studies of (non-fiction) films, its existence grounds the second plea of this chapter, namely that the historiography of visuals may benefit from a double *decentring*: provincializing Europe and North America, as well as big players.

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