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Epidemics, interzones and biosocial change:
retroviruses and biologies of globalisation in West Africa

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ABSTRACT

Despite impressive advances in biomedical science, the resurgence of infectious diseases poses an emerging threat to global public health. These developments underscore the importance of considering the relationship between biological and social change. This dissertation uses the epicentre of the HIV epidemic in West Africa -- Abidjan, Côte-d'Ivoire -- as a case study to show how epidemics are "crystallizations" of local biological and social factors. The Abidjan epidemic is accounted for in terms of the city's sexual modernity, rather than the common view that migration and prostitution explain the proportions the epidemic took there early on. This view supports recent epidemiological work demonstrating the importance of networks rather than behaviour in determining the scope of HIV epidemics. This sexual modernity has a complex genealogy that stretches back through the modernisation drive of the postcolonial state to colonial practices of government, including colonial strategies for containing tropical diseases, which shaped how Africans engaged with the modern world. As a result, sexuality became an important strategy for self-fashioning. With the advent of the economic crisis of the 1980s, sexuality became increasingly permeable to economic relations. Likewise, with the crisis, the city's therapeutic economy, heavily weighted towards the consumption of biomedicines, shifted resort for illness from the public health sector to the informal economy. This may have led to inappropriate treatment of sexually transmitted infections and increased re-use of needles, fuelling the epidemic further. Contemporary efforts to address the epidemic demonstrate how "bio-social" crystallizations can further effect social and biological change. The interface between local groups and international organisations is a site where transnational discourses of "empowerment" of people with AIDS, predicated on a western model of "self-help," encounter the local reality of poverty and illness. In this site, conceptualised as an "interzone," access to transnational resources is traded for, and translated into, local knowledge. This work of translation and exchange entangles actors in complex "moral economies," or relations of obligation and reciprocity, resulting in hybrid forms of social relations that are used to access resources. Effective biomedical treatments for HIV, available since 1996, have remained largely inaccessible in Africa because of their cost. Consequently, these "moral economies" determine access to these biological treatments. This has resulted in biological changes, such as visibly improved health and the emergence of drug-resistant viral strains. These changes in turn impact on social relations, as the inequality of access fuels competition within groups and both local and interational activism for access to treatment. These bio-social changes occur in these "interzones," suggesting that these sites may drive bio-social change much in the way evolution is accelerated in ecological transition zones.

RESUME

Malgré l'avancée spectaculaire de la biomédecine, l'émergence des maladies infectieuses menace la santé publique à l'échelle mondiale. Ces développements soulignent la pertinence d'une prise en considération du lien entre changement biologique et changement social. L'épicentre de l'épidémie du VIH, à Abidjan en Côte-d'Ivoire, illustre bien comment les épidémies représentent des « cristallisations » locales de facteurs biologiques et sociaux. Cette thèse appuie les travaux épidémiologiques récents qui impliquent les réseaux plutôt que les comportements dans le développement d'épidémies comme le VIH, car elle attribue l'importance de l'épidémie Abidjanaise à une « modernité sexuelle », plutôt qu'à la migration et à la prostitution. La généalogie de cette modernité sexuelle comprend la volonté de modernisation de l'État postcoloniale ainsi que les pratiques gouvernementales de l'État colonial (y compris une panoplie de stratégies pour gérer les maladies tropicales), qui ont façonné l'adhésion des Africains au monde moderne. Les moeurs sexuelles représentaient un élément clé de cette stratégie, une façon d'agir sur soi-même qui permettait de mieux affronter les réalités matérielles. Avec l'avènement de la crise économique des années 80, la sexualité est devenue d'autant plus perméable aux relations économiques. La crise a également fait basculer l'économie thérapeutique de la ville, fortement axée sur la consommation des spécialités pharmaceutiques, vers un secteur informel. Une telle situation a pu contribuer à l'épidémie par le traitement inadéquat des infections transmises sexuellement et la réutilisation des seringues. La lutte contemporaine contre l'épidémie montre comment de telles cristallisations biosociales peuvent amener d'autres changements biosociaux. L'interface entre les groupes locaux et les organismes internationaux est un site où les discours transnationaux sur l' « habilitation » des personnes vivant avec le VIH, construit sur un modèle occidental d' « auto-soutien » (*self-help*), rencontrent la réalité locale de la pauvreté et de la maladie. Dans ce site, conçu comme une « interzone », l'accès aux ressources transnationales est transposé en savoir local et échangé contre celui-ci. Ce travail de transposition et d'échange entraîne les intervenants dans de complexes « économies morales » ; c'est à dire, des relations de solidarité et de réciprocité. Il en résulte des formes hybrides de relations sociales. Des traitements efficaces pour le VIH existent depuis 1996, mais leur coût les rendent largement inaccessibles en Afrique. Il en découle que ces économies morales conditionnent l'accès aux traitements. Un tel phénomène amène des changements biologiques, comme l'amélioration visible de la santé ou l'émergence de souches résistantes, qui à leur tour influent sur les relations sociales. C'est ainsi qu'on assiste à des rivalités et à une concurrence entre les groupes d' « auto-soutien » et à l'intérieur même de ceux-ci, ansi qu'à un militantisme accru au niveau local et international pour l'accès aux traitement. Ces changements biosociaux ont lieu dans ces « interzones », ce qui laisse croire que ces sites conduisent au changement biosocial, un peu comme les zones de transition écologiques accélèrent l'évolution biologique.

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Introduction

Epidemics, interzones and biosocial change: retroviruses and biologies of globalisation in West Africa.

Introduction

This dissertation addresses two separate, but related problems; one practical, the other theoretical. Practically, it inquires as to why efforts to respond to the HIV/AIDS epidemic in Africa have been such a massive failure, both in curbing the spread of the epidemic and in caring for those afflicted. Theoretically, it asks how the relationship between biological change and social change may be conceptualised. These questions will be addressed by taking the HIV/AIDS epidemic in West Africa, particularly at its epicentre in the city of Abidjan, Côte-d'Ivoire, as an empirical case study and will draw on evidence from three empirical areas. First, contemporary biological understanding of the evolution of HIV will be discussed in light of the epidemiological data from West Africa which will be examined both in comparative perspective and in light of insights offered by the growing field of the molecular epidemiology of the virus. Second, the historical and social science literature on Abidjan will be reviewed in order to determine how these can explain why this city is where the epidemic has taken the greatest proportions in the region. Finally, ethnographic fieldwork will be used to illuminate the historical, sociological and epidemiological picture. This fieldwork was conducted from 1995 to 2001 with community groups involved in responding to the AIDS epidemic in Abidjan and in Ouagadougou, a city strongly linked to Abidjan both by historical migration patterns and by contemporary cultural flows. Fieldwork in Abidjan was based at a biomedical research institute,

and was broadened to collect ethnographic data on life in the city through the perspective of a diversity of religious and social groups.

The scope of the problem

The HIV epidemic offers a dramatic and increasingly well-studied example of how phenomena at the interface between biology and society can have significant consequences. In the twenty years since this new disease was reported, roughly 50 million people world-wide have been infected with the retrovirus HIV (Human Immunodeficiency Virus) which causes AIDS; 15 million have died. Of the 35 million estimated to be living with HIV, over 25 million are believed to live in sub-Saharan Africa, the world's poorest continent. On that continent, what little public health infrastructure existed up to the 1980s has since crumbled. This, combined with the current lack of access to treatments for this chronic viral infection, means that most of these people will die of HIV related complications over the next 5 to 10 years. Meanwhile, the spread of the infection continues largely unabated. Countries that have managed to reign in the epidemic — Uganda and Sénégal, for instance — contrast with others where the epidemic has raged unchecked. In the Republic of South Africa, seroprevalence rates soared from 2% of the population to over 20% of the population between 1990 and 1998 (UNAIDS 2000). In several countries over a quarter, and in a handful, up to a third of the population is infected. In these countries, decreases in GDP and even in population size are being seen as a result of the epidemic; the statistical chance that a currently uninfected teenager will contract HIV and die from it is over 60%, indicating that the demographic and socio-economic impact will be felt for generations to come.

The epidemic has spawned a diverse trans-national social movement, as well as a major biomedical research effort. The relationship between the two has been complex, antagonistic, and productive of new knowledge, new forms of social organisation, and new biomedical interventions. It is now possible to speak of both as elements of a transnational "AIDS industry," a term which captures the specificity and cohesion of the coalition of individual and institutional actors that have come together to combat the epidemic. This AIDS industry is transnational in scope, linking international institutions (such as UN bodies, multilateral

cooperation agencies and nongovernmental organisations) with a diverse array of local actors and agencies all over the world. These include pharmaceutical firms, gay activist groups, health care workers, community organisations, self help groups, the ill themselves, evangelists and prophets of all sorts, even racketeers and various therapeutic entrepreneurs. Despite this diversity, its core ideology is bio-medical. The fundamental concepts, beliefs and commitments shared among those active in this industry revolve around biological notions of pathogenic agents, contagion, the body, and disease, as well as derivative psychological and sociological notions of risk and behaviour (occasionally more broadly understood as agency). As a result, this industry shares a set of practices that are standard all over the world. These include various public health strategies for raising awareness of risk, social marketing of condoms, counselling, as well as various technical biomedical manoeuvres and interventions taking place in laboratories or at the bedside of the ill.

The AIDS industry can be credited for a therapeutic revolution, as biomedical treatments are now available which effectively shut down the virus in the bodies of those infected, allowing them to live productive and healthy lives. However, these therapies are largely unavailable outside of wealthy countries that are able to collectively support their cost through public and private insurance schemes. Those who are afflicted with HIV live for many years, perhaps decades, particularly with access to treatment; enough time for many to be diagnosed and become politically active. As a result, increasing attention has now shifted to the issue of access to treatment for the vast majority of those infected who live in the Third World. This is particularly problematic because HIV is unlike most other infectious diseases because, even with treatment, the infection is so chronic.

Access to antiretrovirals and treatment advocacy on the part of AIDS activists are just two examples of how the epidemic cannot be understood only in terms of social or biological change. As we shall see later in this dissertation, the impact of such disease-based activism is not limited to influence on health policy or cultural representations of the disease. Increased access to treatments changes the course of the disease as individuals' health improves. However, it also changes the biology of the disease itself by providing selection pressure for the pathogen — HIV — to mutate, particularly in settings where access to treatment is patchy or uneven. By changing the face of HIV disease, the advent of effective antiretroviral

treatment (or "HAART", for highly active anti-retroviral treatment) has transformed the social movement that sprung up around the epidemic, and through it society itself.

Historical studies of the relationship between the biological and the social have long demonstrated that biological phenomena are significant variables in explaining historical events; for instance, the role of infectious diseases in the peopling of the new world makes any presumed European technological superiority a moot point (Crosby 1986). In contrast, it has been argued that endemic tropical diseases hindered European conquest in Africa and Asia. Further, social changes wrought by colonialism have been identified as the source of epidemics in Africa; in turn these inflected the millenarian idiom of many of the colonial resistance movements that foreshadowed nationalism in the continent (Ranger 1986). This literature has tended to move us away from purely technological or environmental-determinist views to dialectical approaches that stress the relationship between environmental constraints, historical events, and biological evolution (Diamond 1997). Being historical in scope, however, the impact of contemporary biomedical technologies and globalised cultural flows in accelerating and inflecting these dialectics has not been part of these studies.

This study concurs with these broad historical studies of epidemics and civilisation in arguing for considering social change in relation to biological phenomena. As we shall see, however, it is increasingly difficult to maintain that biology stands outside of history, as a passive, external constraint that is impermeable to local social phenomena. This dissertation describes one example of the relationship between biological and social change. In so doing, it hopes to underscore the relevance and describe the challenges of understanding these inter-relationships to the future of global public health. In order to accomplish this, the dissertation draws on a variety of disciplines and theoretical approaches that advance three claims: that retroviral epidemics are distinctly "modern" epidemics; that globalisation and biological change are intrinsically linked; and that the manner in which social relations exercise and circulate power is both legible in the distribution of bodily affliction and is amenable to critical analysis in everyday life.

The argument

I argue in this dissertation that biological and social change cannot be considered in isolation from each other. Social relations and biological variation are entangled and co-produced. While this is always a dynamic and fluid relationship –both are evolving all the time—it may "crystallise" into more stable phenomena at particular moments in space and time. For example, HIV epidemics may be thought of the dynamic inter-relation of viral evolution and social change that, once crystallised, persist as stable phenomena; for instance, the endemicity of the infection and the institutions that arise to deal with it. As I will show, these "crystallisations" take diverse forms – they may be pathogens, representations, commodities, practices, biological agents, or patterns of resort. They are legible as cultures, scientific facts, local biologies, and institutional discourses, and circulate along material networks traced by trade and communication routes, as well as systems for storing and retrieving information. In turn, these provoke further crystallisations and concatenations of social relations and biological variations, not unlike a chemical chain reaction.

Specifically, I show that the HIV epidemic in Abidjan is the crystallisation of historical, biological and social conditions specific to the city and its position within a wider network of global economic and cultural flows. The individual and social responses to the epidemic in Abidjan and its hinterland constitute yet other biosocial configurations that stem from and radiate out along social networks. This will be shown drawing on historical and ethnographic data that will be presented below. Four points follow from this observation.

First, social change does not only occur in terms of representations, social structure or culture writ large. Social change is also legible in the material reality of biology and, through it, embodiment — the experience of that biology. Social change alters the distribution of illnesses in population, and, through this, the experience of embodiment in individuals.

Second, embodiment informs the actions of individuals who draw on a diverse array of tactics to improve their material conditions, in the process changing both social relations and biology. Specifically, embodied experience is embedded in social relations that inform patterns of therapeutic resort. Through the medium of

the body, biological change is apprehended and informs actions which reconfigure social relations and biology, as, for example, when different perceptions of illness may lead to different interventions being resorted to, with consequently divergent biological and social outcomes.

Third, culture is a strategy for mediating social change. I understand culture as the collective representations and shared practices through which people understand their position in the world and attempt to act on it (Durkheim 1985, Bourdieu 1977). In the colonial and postcolonial context of this study, social change results from domination and constraint. This creates a shifting terrain of social possibilities and results, over the long term, in the individualisation of fate. That is, people are increasingly brought to imagine their futures in terms of individual capacities, strategies, and possibilities. In this context, culture can be used to refer to the shared, but individualised, imaginary that informs individuals' actions.

The fourth point is that in a setting characterised by material deprivation and social inequality, culture is drawn on both pragmatically and tactically (Lock and Kaufert 1998, De Certeau 1990). What is at stake in culture, then, is not cultured meanings, but rather physical survival, to which meaning is subordinated. Culture can be understood as the sedimentation of the practices by which people "get by" in this setting. Culture furnishes a practical "toolkit" for accessing resources, either through economic strategies or social relations. In a setting where biomedicine is the dominant healing tradition resorted to, and where illness is very common, culture has a powerful potential to change biology.

Biological change is therefore overdetermined. Biological changes may be the direct result of social changes, as in the case of the HIV epidemic that is the focus of the first part of this study, or it may be shaped through cultural responses to social changes, as in the case of the AIDS industry discussed in the second part the dissertation.

Biosocial change must be understood in spatial, as well as temporal terms. Change does not unfold from innate processes, but occurs through confrontation, exchange, negotiation, and domination between social relations and biologies that have varying degrees of locality and mobility. Thus, biosocial change is to be

understood in light of the circulation and material trajectories of pathogens and therapies, but also practices, narratives, commodities, and technologies. These are transmitted along gradients of power. That is, differences in power, which may be legible along a continuum that stretches from abstract — but nonetheless material — distributions of socio-economic inequality to embodied relations of domination, determine the velocity and force with which these pathogens, therapies, and practices circulate.

"Things" — commodities — have a social life, and their circulation across localities and different forms of social relations allow commensuration across different régimes of value (Appadurai 1986). This notion is useful to understanding how the circulation of ways of doing, telling, and making may also circulate across localities and different forms of social relations. I argue here, however, that while the circulation of these practices, narratives and technologies calls attention to a politics of value, they must be examined from the perspective of those affected. For these individuals, what is at stake in the circulation of these practices is the negotiation of different moral economies; that is, differing systems for valuating obligation and reciprocity to others in times of need. As we shall see, that negotiation is shapes social relations, subjectivities, and forms of embodiment.

Central to this dissertation is the notion of an interzone, conceptualised as the social space at the border between globalised cultural forms and local knowledges and practices. It is here that portable technologies are negotiated, exchanged and translated into locally productive phenomena. It will be demonstrated that interzones are sites of accelerated social change and, in some cases biological change, in the same manner that ecological transition zones are considered to be sites of accelerated biological change.

Structure of the argument

Introduction: origins and biology

The dissertation begins with an introductory chapter, followed by three sections of three chapters each. The first chapter reviews evidence from the molecular biology and epidemiology of HIV. HIV is an organism whose genetic structure

predisposes it to diversify rapidly. This makes it particularly efficient at adapting to different biological environments, for instance, by acquiring drug resistance. Molecular epidemiology allows viral variation to be tracked in space and time, giving a picture of its spread and allowing this to be correlated with social conditions. A number of social conditions have been identified that amplify epidemics: epidemics of shared needle use, sexually transmitted infections, warfare, rape, and forced migration. These have been raised in controversies over the origins of the epidemic in Belgian Africa, and point to the importance of an understanding of how social and biological changes interact. In addition, the molecular geography of HIV suggests that these conditions change the pathogen itself, as they facilitate viral recombination and mutation. HIV can be conceptualised as genetic information that is conducted along social pathways. Thus HIV epidemics are the result of particular biosocial configurations of social networks, local disease ecologies, representations of sexuality, and economic relations.

As the epicentre of the epidemic in West Africa, Abidjan offers a compelling site for understanding how these biosocial changes are configured. While it is widely believed that migration and prostitution explain the proportions of the epidemic in Abidjan, these factors are present elsewhere in Africa and gloss over other evidence which shows that differences in sexual behaviour alone do not explain differences in epidemic proportions. As a result, I argue that specific local conditions must be explored in order to get a broader understanding of how these epidemics happen.

Section I: Colonial social change and culture as a mediating strategy

The next three chapters (2, 3, and 4) explore, in historical context, how local biological factors and social relations sedimented in the urban space of the city and the material practices through which Africans engaged with colonial reality. Thus, chapter 2 considers the colonial origins of Abidjan. As a colonial city, Abidjan was the product of a colonial state that sought to dominate a territory as well as the threat of epidemic diseases. Colonial domination was visible in the physical disposition of the city, in that settler concerns over epidemic diseases led to the segregation of Africans from Europeans and struggles over land and housing. Colonial anxieties about "diseased natives" were a self-fulfilling prophecy, as they constrained Africans to live in insalubrious conditions. The

nascent colonial economy commodified African labour, fuelled the city's growth, and instilled a culture of mobility amongst Africans. Colonial mobility was regulated through the state's economic development policy and a panoply of governmental practices that classified, enumerated, and mapped Africans. For Africans, these techniques of government crystallized a notion of ethnicity as a strategy for negotiating social change in colonial times.

Social change was negotiated by Africans in a diverse array of social spaces that, while tolerated by colonial officials, nonetheless constituted spaces of potential dissent as well as sociality and play. Chapter 3 considers three types of spatial practices through which African engagement with colonial modernity was manifested. Ethnicity was produced by the colonial state's practices of mapping the colonial territory, and it was appropriated by Africans to position themselves within the colonial economy, particularly the plantation economy. The combination of colonial mobility, reproductive strategies and ethnicised economic tactics solidified ethnic groups. Prophetism, heralded by the 1913 mission of the Prophet Harris who travelled to Côte-d'Ivoire from Liberia, ushered in a trans-local public sphere that allowed Africans to reflexively engage with colonial modernity. Subsequent prophetic cults and religious syncretisms were idioms for negotiating colonial modernity. Their efficacy is attested to by the ease with which prophetic zones cleared the underbrush of "tradition" to adopt the new economic practices of the plantation economy. Finally, urban voluntary associations were sites for the diffusion and adoption of new cultural forms such as theatre, dance, sports, and writing — nodes in discursive networks that circulated knowledges and practices that sedimented as a modernist culture, defined against an imagined, "traditional" other. Taken together, these spatial practices indicate that "tradition" and "modernity" were purifications produced out of a hybrid and fluctuating social reality. Significantly, this demonstrates that culture is a strategy for mediating social change and therefore that straightforward culturalist explanations for epidemics obscure how social change produces epidemics.

Turning to the postcolonial period, chapter 4 examines the modernisation programme of the postcolonial state. The "high modernism" of this program was visible in the adoption of a modernist aesthetic in urban planning and the attempt to install a legible social order. Abidjan's street grids, and striking modernist architecture were paralleled by commitments to mass education and a *dirigiste*

state that developed an export oriented economy to finance its modernisation programme. *Abidjanais* appropriated modernity, through their housing strategies but also in their engagement with the new social landscape afforded by postcolonial institutions. This led to an individualisation of economic strategies, as people increasingly imagined their futures in terms of personal choices in education and vocation.

Section II: The urban culture of modernism: economy, sexuality, and therapy
The three middle chapters (5, 6, and 7) trace the genealogy of what I call a culture of modernism, whose birth coincided with the global capitalist crisis of the 1970s that aborted the state's modernisation program. This culture of modernism remained robust despite the inability of the state to deliver on its "promissory notes," leading to a hybrid social world where individuals must constantly mediate between kin- and village-derived social relations and the anonymous but potentially enriching social world of the city. The relevance of this culture of modernism and the economic context in which it took hold for the HIV epidemic is explored in Chapter 7 (see below).

As the crisis depressed export prices, the Ivorian economy, heavily dependent on revenues from export crops, collapsed. The result, as will be shown in Chapter 5, was increased social inequality within social groups and the blossoming of the city's "informal economy," when people resorted to innovative economic strategies to survive. The impact of the postcolonial state's failed modernisation drive was most felt by young people, who were "deschooled" as state investments in education were scaled back and parents were no longer willing to invest in modern education. Nonetheless, these young people created original and individualised tactics to survive. These tactics rely on the "art of social relations" and "social dexterity," as will be shown, and were adopted according to personal trajectories and aptitudes. The informal economy and a legacy of protest conjugated to create an urban culture particular to Abidjan, expressed in its dialect — *nouchi* — and other popular cultural forms: dance, music, habitus, and style. This culture was resolutely *modernist*, both in its lamentation of failed modernity and its aspirations for a better future expressed in terms of modern employment and consumption.

This urban culture expressed and reflected the advent of a sexual modernity in Abidjan (chapter 6). The crisis accelerated the economic empowerment of women, and with the modernist emphasis on individualism, sexuality was much discussed. Sexuality became a forum for expressing anxieties about social change, and also became available as a strategy for "self-fashioning." Evidence that Abidjan's sexual modernity may have been early relative to what occurred later in neighbouring African cities is drawn from accounts gathered in the city's homosexual *milieu* in the 1970s, when Abidjan was already identified as a place where a broader range of sexual identities could find social expression. Ethnographic data from the contemporary homosexual milieu documents that sexuality is highly permeable to economic relations. In a context where tremendous social inequality exists within the undifferentiated social spaces of the city, sexual desire juxtaposes with economic need to broaden sexual networks. The power of the sexual imaginaries of some to fashion the sexual identity of others flows along economic gradients and is disseminated by an "epistemology of rumouring." In situations where kinship networks do not conduct information very well, rumours about individuals and their personal characteristics furnish the "intelligence" necessary to reading social relations and adopting the appropriate tactics for mobilising resources from those relations.

The modernist culture also influenced Abidjan's therapeutic economy, defined as the totality of therapeutic options and the strategies used for accessing them. As will be shown in chapter 7, colonialism and the state's modernisation program developed a biomedical infrastructure but also enacted a biomedical hegemony within the therapeutic economy. The efficacy of biomedical treatments in treating the most common pathologies — infectious diseases — in this area combined with the modernist culture of the city to make biomedicine the preferred option of resort. This is particularly visible in the city's private biomedical sector and its informal economy for medications. The economic crisis hollowed out the facilities of the public health system and decreased incomes, pushing biomedical resort into the informal sector. The result was an increasingly irrational use of biomedicines in general, and antibiotics in particular. These changes are hypothesised to have led to an early spread of the epidemic through inappropriate treatment of sexually transmitted infections and high rates of exposure to reused needles. Interviews with health care professionals indicate that this was common both in the informal economy — local injectionists and unregulated dispensaries

— and in the public health sector. Epidemiological evidence for this hypothesis is sketchy but suggests the hypothesis warrants further investigation.

Section III: The AIDS industry, confessional technologies, and therapeutic citizenship

Having argued that the HIV epidemic is the crystallisation of the biosocial changes outlined in the previous two sections, the final section examines how the response to the epidemic is, in turn, changing social relations and local biologies. These changes need to be understood within the broader landscape of constraint structured by globalisation, capitalist concentration, and increasingly "weak" third world states. These phenomena, it is argued, have left much of African society to fend for itself and have left it particularly permeable to the interventions of international agencies and actors. These interventions are negotiated in an intermediary space that I call an interzone, where local knowledge is traded for access to resources.

Chapter 8 examines the response to the AIDS epidemic by following three NGOs that have been mobilised as a result of the epidemic. The story of these organisations shows how the discourses of development agencies created a market for AIDS testimonials, challenging the "moral economy" in which those involved found themselves. The term "moral economy" is used here to indicate social relations embedded in regimes of value and networks of reciprocity that do not necessarily imply the exchange of objects. It also reflects the profound sense of moral difficulty the circulation of these practices — such as testimonials — provoked in those who spoke out, or who felt compelled to make others speak out, about being HIV positive. While some organisations were able to negotiate new forms of solidarity amongst their members by using idioms of state organisation to enforce hierarchies, others collapsed in a welter of bickering, rivalry, and recriminations, betraying the original intentions of the development agencies.

Chapter 9 focuses on the techniques used to elicit these testimonials. This chapter explores how these confessional technologies circulated from an American context of self-help, to Europe, before being brought to Africa by well-meaning development workers who sought to foster "self-help" amongst Africans with HIV. However, in a context of poverty and material want, Africans with HIV do not

necessarily view talking about their problems as their first priority. They are more concerned with obtaining medicines and other material resources. Yet illness narratives are a highly valued commodity for development agencies, which use them as evidence of local efficacy to access resources on the international stage. As a result, local community groups mediate between the needs of their members and those of international agencies. This work of translation is productive of new regimes of value and moral economies that are not necessarily concordant with the intentions of either local members or international agencies.

Nowhere is this more evident than in the circulation of antiretroviral drugs, which have begun to follow the paths traced by AIDS testimonials. As will be shown in chapter 10, the social networks have sprung up between AIDS groups in the south and in the north play an important role in the circulation of these biologically active agents. Access to these drugs in the African groups was mediated by social relations and, particularly, the ability to mobilise an effective illness narrative. These drugs, when rigorously adhered to, restore health indefinitely, they have fashioned the subjectivities of the lucky few who have had access to them. Restoring health also influences the perception others have of these treated individuals within their social networks. Political pressure generated by transnational advocacy networks around the issue of access to treatment in Africa will likely broaden access to these drugs. However, the experience of the UNAIDS initiative discussed in this chapter suggests that, unless these measures are accompanied by substantial commitments to rebuild public health infrastructure in order to support patient adherence to these treatments, punctual initiatives designed to address western guilt will only succeed in creating epidemics of drug-resistant virus. In contrast, a growing market for clinical data from developing countries suggests that clinical trials will become an important mechanism of access to therapy. This poses the troubling question of how global inequities in access to health and the distribution of diseases are articulated with the growing market for clinical science, and suggests that bio-capital may become more deeply implicated in these processes of biosocial change. Concurrently, therapeutic citizenship, the ability to make claims on others for treatment based on one's disease status, has become an increasingly important survival strategy in settings where neither kinship nor a weakened state can offer guarantees against the vicissitudes of life, and where illness claims carry more weight than those based on poverty, injustice, or structural violence.

Theoretical framework and research questions

The determinants of modern plagues

In this project, I follow others in making the claim that emerging epidemics (such as multi-drug resistant tuberculosis, malaria, ebola, yellow fever) are "modern plagues" resulting from the combination of steepening transnational social inequality (often attributed to globalisation) and the breakdown of global public health (Farmer 1999, Garrett 2000). Significantly, it is not poverty as such, with its well known causal web of malnutrition, overcrowding and poor sanitation, that drives these epidemics. Rather, it is social inequality.

The notion that socio-economic inequality, or *relative* poverty, results in ill health, independently of the contribution of *absolute* poverty, derives from epidemiologic studies conducted in northern countries. These studies have shown that heightened socio-economic gradients generate a "hierarchy effect" which distributes mortality disproportionately on to those who are lower down — or "relatively deprived" — on the hierarchy. The pathways by which such hierarchy effects are mediated remain poorly understood; the three leading hypotheses invoke either materialist pathways (inequality leads to differences in material circumstances which adversely affect health outcomes), psychological pathways, such as the notion of internalised stress (John Henry syndrome), or social pathways that result in diminished social cohesion (Blane 1998, Wilkinson 1998).

In developing countries, however, social inequality differentially affects health outcomes by less mysterious means. Heightened gradients exacerbate inequalities in access to biomedical treatment, leading to a two-tiered medical system. This plays out according to two scenarios. In the first, presence of private biomedical care means that the well-off pay for treatment and governments have little incentive to subsidise care for the poor who have little political influence. In the second, the requirement that public health facilities implement some form of cost recovery, imposed through structural adjustment programmes in the 1980s, leads to the imposition of user fees which effectively render care unaffordable for the poor. In both cases, the greater the inequality, the less political will there is to

invest in public health (preventive interventions such as sanitation and curative biomedical services) for the poor. This is further discussed in Chapter 7.

This is of particular relevance in developing countries because most of the burden of morbidity and mortality in the population is made up of infectious diseases (diarrhoeal diseases, malaria, tuberculosis, HIV and so on) for which causal pathways — and effective prevention interventions — are well known, and biomedicine remains the only effective treatment. Differential access to public health services thus has a significant impact on health outcomes[1]. This is compounded by differential access to ecological determinants, such as clean water and sanitation, that affect the risk of acquiring diseases. In other words, interventions to improve the environment (in public health terms, "hygiene") are a form of preventive medicine, acting to decrease the risk of acquiring diseases rather than treating existing diseases.

Empirical studies indicate that breakdowns in public health services are implicated in epidemic outbreaks, and some work suggests that such breakdowns may actually fan epidemics, as in the case of multi-drug resistant tuberculosis (MDRTB) and Ebola (Farmer 2000). Indications that public health systems are collapsing in many parts of the world are paralleled by the proliferation of biomedical technologies across the globe[2]. In short, biomedicine has suffered a wholesale privatisation on the global level.

The result has been a fragmentation of biomedicine into multiple, segmented markets, ranging from birth control and, in some cases, generic medicines for the poor, to artificial insemination and organ transplants for the wealthy. The globalisation of biomedicine has encouraged the fragmentation of public health, and its increasingly irrational organisation. Public health measures — whether sanitation, vaccinations or antibiotics — are not as effective if these measures are only applied to part of the population. Unclean water in shantytowns can contaminate the water supplies of the rich; inadequate vaccination levels disables

[1] This is not the case in developed countries, where the burden of morbidity is for chronic diseases, where consumption of biomedical health care seems to impact mortality minimally

[2] Evidence ranges from economic data on the growth of the global market for pharmaceuticals and medical products to ethnographic data on the use of biomedical technologies in developing countries, as in the case of foetal ultrasound in India and China

herd immunity mechanisms and increases the odds of serious vaccine failures; partial antibiotic use leads to resistant strains that can contaminate even those who can afford full courses of antibiotics. Rational organisation of biomedicine — that is, its organisation into institutions that are accountable to broader public health goals and not just the advancement of individual gain — ensures a large part of its actual "real-world" efficacy.

Spreading antibiotic resistance is but one example of how partial access to biomedicine might be even worse than none at all — in other words, biomedicine's efficacy is an "all or nothing" proposition. In highly rationalised settings, "patchiness" is a marginal problem. This is because, in these contexts, strong states ensure the political and economic stability that allows the distribution of health risks across the population and security through health insurance schemes. In addition to ensuring access, strong states furnish the juridical framework for the regulation of the biomedical profession. This enforces education and practice standards, avoiding dangerous misuse of biomedical technologies. Medicines work only if patients take them; it is the rational organisation of biomedicine that allows patients to get accurately diagnosed, prescribed the right medicines, and receive the kind of follow-up care that helps them keep up their treatments.

This dissertation is concerned with the implication of biomedical globalisation in the epidemic consequences of social inequality. The emerging literature on "modern plagues" and new infectious diseases suggests that social inequality plays a pivotal role in driving these epidemics, and that gaps in biomedical infrastructure and care have unwittingly played a role. Under-equipped hospitals and public health programs lead to the re-use of needles and other potentially contaminated equipment and inadequate monitoring of drug therapy, fuelling epidemics such as HIV, MDRTB, Hepatitis C and Ebola. Today's widespread presence around the world of biomedicine has its roots in an earlier epoch of globalisation, the colonial era, which introduced most of the world to biomedicine. Biomedicine's colonial past was rapidly forgotten in the postcolonial period; for newly independent nations and peoples biomedicine was emblematic of entry into modernity and the promise of therapeutic success that advances in treatment of infectious diseases, that they had often witnessed, heralded. The inability to sustain public health in today's economic climate has shifted the

increasing cost of biomedicine onto individuals whose ability to pay for the care they seek is precarious. The result has been a greater role for iatrogenesis in the spread of epidemics. While poverty results in homogeneous inaccessibility to biomedical care, globalisation together with increasing social inequality puts some biomedicine in the reach of even the poor some of the time, amplifying the potential role of iatrogenesis.

Global gradients of inequality have largely escaped notice because they are trans-national and therefore not captured within national studies. While the political mechanisms by which social inequality results in ill health within nations are well understood, the manner in which trans-national social inequality, and trans-national political activity, impact on health have yet to receive serious scrutiny. The popular term globalisation is most often used to point to the intensification and acceleration of flows of capital and, with it, commodities and cultural forms. As many critics have pointed out, we may have a truly global economy from the point of view of capital, but labour remains pooled within national borders and unable to circulate freely. My hypothesis is that it is precisely in this patchiness of globalisation, the fact that some things (such as medicines) circulate while others (the ability to use them properly) do not, that the key to understanding these modern plagues is to be found.

The nature of globalisation

The link between the breakdown of global public health, increased social inequality, and retroviral epidemics points to the larger question of how social and biological change might be related. Contemporary discussions of social change are most often framed in terms of globalisation, a term that has the advantage of capturing a multiplicity of cultural, economic, political, and social processes that transcend national boundaries. Succinctly put, the globalisation thesis states that such trans-national processes are the most important determinants of social change in the contemporary world.

This represents an important shift away from modernisation theories of the 1960s that viewed social change as occurring when individual nation states travelled along the path of socio-economic modernisation, often taken to be equivalent to industrialisation. For modernisation theorists, cultural and social obstacles littering that path were invoked to explain differences in the velocity at which

different countries travelled, or indeed whether they ever got to the desired destination of a modern society (Roxborough, 1988).

Critics of the modernisation thesis countered that these obstacles were not accidents of culture or history; rather, they were structural deformations inherent to the nature of global exchange. This Marxist view understood underdevelopment as a mechanism for concentrating wealth by extracting raw materials from peripheral countries in order to process them in the industrialised core and sell them back to the periphery, fostering a relationship of dependence (hence, "dependency theory"). "Dependency theory" is often associated with the "world system" school of sociology, whose insistence on treating the world as a system provided the guiding framework for the analysis of international trade as productive of underdevelopment . Neither modernisation theorists nor world-system theorists seriously questioned the primacy of the nation-state in their analysis, assuming (along with international relations scholars) that states were an elemental unit of analysis; nor did they consider the political processes of domination that produced unequal processes of exchange (Held and McGrew 2000).

Sociologies of globalisation have drawn on this debate to develop more refined analyses that question the 'naturalness' of the state, and incorporate developments since the 1960s, most notably technological innovation and transnational political processes, in the analysis of the "new world order" of globalisation. Most analysts see the shift from Fordist methods of mass-production and Taylorist management practices to "flexible" production after the oil crisis of the early 1970s as an important turning point, a move to a more virulent form of mobile, "post-Fordist", "disorganised" capitalism (Amin 1994, Lash and Urry 1987, Lash 1990). New forms of production were facilitated by the new financial world order that facilitated capital flows, as well as in the hyper-differentiated consumer culture of postmodernism. The spatial reconfiguration of capitalism has been accompanied by "space-time compression," the perpetual acceleration of cycles of production and accumulation (Harvey 1994). Others have seen a shift to an "information" or "network" society, where information may even replace capital as the primary determinant of production (Castells 1996, 1997). All have underlined the changing role of the nation state, and the rapid shifts in national fortunes that

have been engendered by a "new" world economy characterised by instantaneous capital flows and the increased mobility of technology.

Processes of globalisation have been linked to widespread industrialisation and concentration of the agricultural industry; similar corporate concentration is currently occurring in the pharmaceuticals industry, as witnessed by waves of pharmaceuticals mergers. These new transnational concentrations of capital, combined with unprecedented power to intervene in human and nonhuman biology[3], accelerated and intensified circulation of biological agents[4], and new industrial processes of agricultural production[5] have the potential to transform biology in unexpected ways.

Vigorous debate exists regarding the extent to which contemporary processes of globalisation have contributed to new forms of trans-national social inequality, and whether these gradients might be steepening or levelling off. Certainly, economic growth has been parsimonious in its geographical distribution, with Africa the continent that has yet to receive any benefit from the recent expansion of the global economy. Implementation of structural adjustment programs led to the widespread implementation of cost-recovery (charging of fees for services) in the African health care sector from the late 1980s on, as well as declining infrastructural investments. The result has been a breakdown in public health capacity on the continent, a phenomenon also implicated in the emergence of new epidemics.

Globalisation and biological change

Taken together, it is advanced here that these pathways (capitalist concentration, dissemination of new technologies, and decreased public health capacity) may result in biological change; the term "biologies of globalisation" is used to refer to their study. Biologies range from the ecological to the molecular; a continuum

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[3] Largely through biomedical interventions, from disease treatments to preventive interventions such as vaccination campaigns.

[4] Such as drugs, vaccines, cell lines for culture, and genetic material.

[5] The best known example is bovine spongiform encephalopathy ("mad cow disease"). Recycling of neurological matter from cows in feeds allowed the pathogen, which otherwise would have had no way to spread, to infect herds. However it is not inconceivable that industrial monocultures and GM crops pose similar risks.

that includes the physiological and microbiological. In so doing, I wish to refer to the broad range of phenomena which register as material constraints on social phenomena[6]. The term "nature" (as in "nature versus nurture") has been often used to group these phenomena; I eschew it here because the term suggests a fixed and extra-historical essentialness. This view is discarded in this study precisely because it blinds us to how biology is changed by social and historical developments. The plural (biologies) is used to capture (i) differences in scale (from ecosystem to genotype) (ii) geographical variation in biological phenomena among populations; and (iii) potential plurality in knowledge about biological phenomena, recognising that biological knowledge is always to some extent socially constructed. Biologies of globalisation, then, examine how interactions between global and local phenomena produce "local biologies" (see below) as well as local cultures and knowledges about biological phenomena.

Geographical variation in human biology has received recognition under the term local biologies. Lock's comparative study of menopause in Japan and Canada (1993) introduced the term to account for differences in the embodied experience of menopause. Rather than attribute these differences solely to the influence of language and culture, Lock argued that they were evidence of variation in human biology that could include differences ranging from the ecologic to the genetic. They were taken as evidence that different historical trajectories — environmental and cultural — at both the collective and individual level impact and constrain biology, just as biology impacts and constrains the range of bodily experiences and the meanings that may be attributed to them. Importantly, the term is not used to attribute such differences to the social construction of biomedical knowledge or artefacts of measurement. Nor does it refer to measurable differences in human populations.

Evidence of local biologies alerts us to the permeability of the biological (perhaps even the genomic) to the social. Studies of science have long argued that scientific knowledge is "socially constructed" and contingent (Woolgar 1988). Biomedical knowledge is no exception; indeed, biomedicine is strongly influenced by the political agendas of institutions as well as broader political struggles (Lupton 1994). However, the material reality of biology itself is also socially constructed

[6] In this sense, we can also see in biologies a guarantee of the material.

— an assertion for which the existence of epidemics are the most convincing example. As a result, knowledge of biology, although shaped by social forces (as will be discussed in chapter 10), is nonetheless real and can be used as a tool to examine social phenomena of which it is a reflection.

For instance, growth of biomedical knowledge, particularly in the field of genetics and molecular epidemiology, has a potential to offer rich insight into how the world is changing. This underscores the importance of a reflexive, critical epistemology in the biological sciences. Evidence of local biologies should not be dismissed out-of-hand, but needs to be carefully considered in light of evidence that biology is co-produced along with society. This dissertation argues that biology is permeable to contemporary social change. Therefore, scientific knowledge of biological processes — in this case, the molecular biology and epidemiology of HIV as well as its clinical and comparative epidemiology — furnishes a valuable commentary on these processes of social change, one that is disregarded at our peril.

Social change and globalisation

What is meant by the term "social change?" How can it be studied? This study proposes, as a practical starting-point, to define social change as the shift from one form of social relations to another. For early anthropologists now referred to as structural-functionalists, social change was understood as change in social *structure*, implying shifts in the rules governing behaviour, symbol systems, or values. Change occurred within a dynamic equilibrium, such that the different elements in the system compensated for changes in others to maintain social homeostasis. For later anthropologists, culture came to be understood as both the reflection of social structure and as a buffering medium, an adaptive reaction to change, whether its origin was "social" or even "ecological." The social origins of change were attributed to "culture contact:" the exposure of primitive, traditional societies to European, modern societies that resulted from colonialism. In such analyses, the political dimensions of that colonial contact were often elided (Southall 1961).

As colonialism integrated an increasing segment of the population into the capitalist economy, notably by employing African workers on plantations or in

mines, anthropologists working within a Marxist tradition, understood social relations as a "mode of production." In this view, culture is ideological, serving to mystify or distort the perception of social relations so as to legitimate existing forms of social inequality and perpetuate the grip of dominant groups on power and the production of wealth, whether this was material or social (symbolic). Social change, the passage from one form of socio-economic organisation to another, is the result of politics: struggle for control over the means of production and, eventually, the state. In this view, politics determines culture (Meillassoux 1964).

Contrasting with these views of culture as either a reflection or a mystification of social structure are more recent approaches that have focussed on the role of culture in everyday life. From this point of view, culture appears polymorphous: at times unreflective practice, at other times as strategy or even performance (De Certeau 1990). Corresponding with a heightened reflexivity in ethnography, culture takes on different forms depending on who is using the concept when and where, and who is the observer (Clifford and Marcus 1986). Culture is no longer understood as monolithic, nor as representation. Rather, culture is modular, assembled, disassembled and reconfigured; culture is what people do rather than what people say or think they are doing. "Practice theory" thus marks a break with hermeneutics, the idea that culture can be read like a text and plumbed for deeper meaning (Geertz 1973), as well as with subjectivist biases in ethnographic method. Practice theory allows us to understand how social relations are constituted in everyday life while avoiding the pitfalls of an idealist conception of culture. Culture constructs the social through practice (Bourdieu 1977).

The term "social relations" is preferred here to "society" because it avoids static or reified conceptions of social life and includes the dimension of power in its analysis (Hirst and Woolcroft 1982). Power operates in and through social relations and indeed may even be constitutive of them (Foucault 1987). In political science and classical anthropology alike, power was understood as a form of constraint on individual behaviour exercised from above, either through the actions of a sovereign or the state. Power had an origin (the sovereign) and a destination (the subject); in this sense, it can be defined as "arterial." (Cooper 1994) Arterial power acts through force or the implied use of force; politics can be understood as a struggle to control the source and modulation of power. In

this view, agency is a vertical force, which either resists power or tracks along its paths (Lukes 1974). Rather than seeing power as a constraint imposed from above, either through the actions of a despot, sovereign or the state, analyses inspired by the work of Foucault have argued that power operates laterally, both constraining and potentialising options. "Capillary" power is essentially productive: of commodities, "domains and rituals of truths," and of subjects. This Foucaultian notion of a "micro-physics" of power establishes a functional equivalence with culture in anthropological practice theory. Culture/power operates on several levels; as a discursive apparatus, filtering and regularising what is speakable or thinkable; as a technology of the self, offering a menu of spiritual and physical exercises for self-fashioning; and as a mode of government, a cluster of material practices for ordering, counting and governing bodies.

As a result, changes in social relations can be analysed as transformations in these micro-physics of power. Such transformations signal discursive shifts, changes in the ways individuals constitute themselves as subjects, and transformations in the way populations are counted and managed, as events to which ethnographic attention must be paid. Recalling the hypothesis that globalisation drives social change, a preliminary hypothesis is that trans-national discursive formations, technologies of the self and forms of government transform and are transformed by their local equivalents. Such a definition must also be mindful, however, of the large scale social forces that drive social change from "above;" thus, one would expect asymmetries in this encounter between global and local and in the equilibrium of transformative forces. In other words, the landscape determined by arterial forms of power constrains the circulation of its capillary forms.

Foucault's argument was that in complex societies, such micro forms of 'disciplinary' power have largely taken over from overt, direct forms of constraint exercised by the state. My position is that in areas left derelict by state retrenchment in poor countries, such as cut backs in health care, increasing intervention by international actors has facilitated the circulation of capillary forms of power, that is rituals of truth and processes of subjectification, displacing local forms of capillary power and explicit politics (Pandolfi, 2001).

Inequality, or the uneven distribution of power, is a universal in any society, as witnessed by the fact that in every society misfortune is selective: it affects some

but not others. At its core, medical anthropology is concerned with how different societies understand and manage misfortune. Misfortune is an outcome of powerlessness (the inability to affect events) or powerfulness (the ability to inflict damage to bodies, persons, property). The idea that misfortune may be due to purely random events is a recent, and western, invention. An inherent property of social relations is that they distribute power unequally. Medical anthropologists have shown that societies differ, however, in the way inequality is inscribed in the body (Fassin 1996). Inequality may be marked on the body through initiatory markings that indicate hierarchical rank, or it may be signified in the way bodily affliction is attributed to witchcraft (which is itself the product of inequalities in social relations that produce rivalries, jealousies, and perceptions of ill-will). Or, as in the case of "modern" northern societies, inequality is marked on the body as differences in morbidity, mortality, and usage of biomedical interventions. Thus, the distribution of bodily affliction indexes social inequality, and indeed social relations.

If social change is understood as the passage from one form of social relations to another, these insights suggest that social change is reflected in the way inequality is inscribed in the body. The classical categories of anthropological analysis — kinship, economic organisation, religion — furnish a prism through which the consequences of social change may be viewed.

To sum up, social change can be defined as changes in social relations. Globalisation identifies trans-national or trans-local forms of social relations. These may be trans-national forms of capital, modes of production, cultures ("ethnoscapes"), or coalitions of institutions, one example being the environmental movement (Appadurai 1996, Keck and Sikkink 1998). As a result, globalisation draws attention to trans-national gradients of social inequality. (For example, many critical studies of globalisation have examined how capitalist production today relies on the use of inexpensive labour in the third world to produce goods for the expensive consumer market in the north.) Globalisation-driven social change implies the juxtaposition of trans-national social relations with local social relations, with a disproportionate, transformative impact on the latter. These are available to ethnographic analysis as shifts in discursive formations, methods of subjectification and modes of government. Changes in

social relations are measurable as different distributions of social inequality and its inscription in the body as embodied affliction.

Biosocial change

The notion of "biosociality" has been used to refer to various forms of social relations and movements organised around a shared biological condition such as a disease (Rabinow 1992). Biosociality first became a significant phenomenon with the AIDS epidemic. AIDS emerged as a disease of gay men in America, and gay activism provided a readily available model for organising self-support, fighting discrimination and demanding political investment in seeking prevention against and treatment for the disease. The significance of biosociality has been attested to most recently by the growth of social movements whose principal goal is to legitimate a shared experience by obtaining recognition for it as a disease; in the words of Dumit (2000), there are now diseases one "fights to get," diseases such as chronic fatigue syndrome, multiple personality disorder, sick building syndrome, environmental allergies, recovered memory, gulf war syndrome... Showalter's (1997) labelling of these as "hysterical epidemics" captures the psychological contagion that seems to explain their epidemiology, accelerated by their diffusion through mass media and the American self-help industry, as well as demonstrating a link with earlier forms of epidemic hysteria. However these cannot be dismissed as "merely" psychological conditions, as testified to by the insistence on symptomatology and the biology assumed to underlie it. Nor can the economic environment where these disease claims are made be ignored. Having a "real" disease means, particularly in America, being able to obtain medical care from cost-conscious insurers.

Thus, in the popular culture of contemporary America, shared affliction is an important strategy for building communities. While most of these are "virtual" communities, the existence of "therapeutic communities" of former alcoholics and drug users attests to the power of shared affliction to forge new forms of social relations. Nowadays affliction increasingly needs a biology, or at least, an official diagnosis; affliction is increasingly defined in terms of a (usually absent or difficult to obtain) therapeutic intervention. Expert knowledge is increasingly called upon to substantiate claims made on the State, and other institutions, for redress, compensation or treatment. As these claims register in the political arena, they do effectively shift priorities, mobilise resources, transform social relations and

translate into changes in therapeutic availability and compensation[7]. New diagnostic technologies — particularly genetic technologies — lead to affliction being defined not in fact, but in terms of probabilities.

Biosociality thus draws attention to the potential of biomedical knowledge to organise social relations, as in self-help groups for individuals who suffer from a common disease. These social relations increasingly represent forms of therapeutic citizenship; that is, social relations organised around a shared therapeutic predicament. Studies of these biomedicalised forms of social relations have largely been limited to developed countries, where one could expect that large scale access to biomedicine, and an individualised culture of care-seeking would easily translate into these new forms of social relations. Globalised cultural flows facilitate the circulation of western discourses of self-help and cultural products that advertise self-help widely. Just as African-American cultural forms such as hip-hop have been taken up and Africanised, we might expect that western discourses of self-help have been appropriated in African contexts. Our hypothesis is that dissemination of these therapeutic cultures and citizenships transforms social relations at the receiving end, but also that by translating into political strategies for gaining access to treatment, biosociality can result in biological change, as well as in social change.

[7] For example, PTSD, initially a disease of Viet Nam war veterans, has now become a vernacular diagnosis for organizing interventions on "trauma victims" in refugee camps throughout the world; the "recovered memory" movement, a coalition of victims of supposed childhood sexual abuse and their zealous therapists, tore apart families and even communities throughout America in the 1990s.

Chapter 1
Origins and Biology

Introduction

In the early years of the HIV/AIDS epidemic, discussion about the origins of the epidemic was fraught with accusation and blame. Early reports singled out homosexuals, IV drug uses, hæmophiliacs, and Haitians as "high risk groups," leading to the "four H's" being blamed for the spread of the epidemic. By the time these categories were denounced as inaccurate, it was too late — these groups had already borne the brunt of stigmatisation and exclusion that is characteristic of scape-goating responses to epidemics. Talk of origins became indistinguishable from blaming, and most often it was the victims of the epidemic who were blamed (Farmer 1992).

The time has now come to revisit the question of origins, for three reasons. First, it can be expected that the lessons of the early years of stigmatisation have been learned, and that such discussions will not degenerate into assigning blame. These lessons are the result of early engagement by activists and cultural critics, that revealed the flimsy evidence on which early theories of origins were based, and demonstrated the pernicious consequences they had on efforts to contain the epidemic. Traditional public health methods for controlling epidemics, it was argued, were impractical and exclusionary, and would worsen the epidemic by driving it underground and creating a stigmatising environment that would inhibit the dissemination of prevention education. This marked a shift towards "discourses of empowerment" (Seidel 1993) and a human rights paradigm that has since became the mainstream in efforts to contain the epidemic (Mann, Gruskin, Grodin and Annas 1999). This paradigm stressed that promotion of the

human rights of those at risk for and infected with HIV was crucial for efforts to prevent the epidemic. This "AIDS exceptionalism"[1] is increasingly coming under fire today as the world enters the third decade of the epidemic in far worse epidemiological shape than was initially expected, indicating that careful reconsideration of old orthodoxies is in order.

Second, global public health efforts over the years allow us to paint a detailed epidemiological picture of the epidemic, its evolution and, increasingly, hypotheses about its social determinants. More recently, the growth of parallel computing and advances in our understanding of the molecular biology of the virus have led to a growing field concerned with the molecular epidemiology of the virus. As we enter the third decade of the epidemic, these bodies of knowledge offer the potential for detailed, comparative epidemiologic studies that will furnish a more precise understanding of the epidemic's evolution. This allows for consideration of the question of origins to take place on firm scientific footing. Indeed, public controversy over this issue has erupted with the publication of *The River* (Hooper 1999), which advances a hotly debated theory of the origin of HIV (discussed below). Hooper's book has raised a challenge for the broader scientific community that should be responded to.

Finally, while the term "origins" often connotes a point somehow outside of history, I understand origins to be firmly located within historical and social space. Bashfulness in examining the question of origins has unintentionally deflected attention from consideration of broader social factors that condition the emergence of epidemics. Identifying these factors are of relevance to contemporary public health, especially in light of emerging epidemics such as Hepatitis C. Comparative and molecular epidemiologic studies call for complementary investigation of the social circumstances in which epidemics are embedded. Social studies have largely been concerned with locating the correlates of epidemic spread in individual behaviour, but have so far have shied away from scaling up to investigate how broader structures such as culture, ideology and political economy — in short, power — shape and constrain behaviour. In the case of AIDS, the relationship between power and epidemics has been largely

[1]A term that refers to the use of the human rights paradigm, rather than a more standard infection control paradigm, in the fight against AIDS.

limited to descriptions of power imbalances within sexual relationships. This is a reductionistic view that tends to exaggerate the agency of individuals, and has neglected to examine how agency is fashioned through the operation of culture, ideology and political economy in society at large (Farmer 1995).

As we shall see, the story of the HIV epidemic shows us that both biology and society are historically embedded; that is, both change over time, and that change is driven by their inter-penetration. This chapter will review the evidence for this in three sections. The first will review the molecular biology and epidemiology of the virus to explain how viral diversity can be measured, mapped, and used to extrapolate to the epidemiologic and social factors that condition the epidemic's spread. The second will review the current theories of the origins of the HIV epidemic. Finally, we will turn to the comparative epidemiology of the epidemic in order to explain why Abidjan furnishes an important case study in how the concatenation of biological and social change has driven the HIV epidemic.

The biology of HIV: mechanisms and implications of genetic diversity

The Human Immunodeficiency Virus belongs to a recently discovered family of viruses called retroviruses. Retroviruses are so-called because they share a distinct genetic mechanism for reproducing themselves. They consist of a package of single-stranded RNA encapsulated in a protein envelope. RNA are chunks of genetic information that are usually derived from DNA which is the "master copy" of an organism's genetic material. Normally, genetic information flows from DNA to RNA to protein: DNA is "transcribed" into gene-sized RNA chunks which are then "translated" cellular enzymes which "read" the instructions coded in the RNA sequence (which has been transcribed from the master DNA copy) to assemble proteins[2]. Retroviruses were the first evidence that this flow could occur "backwards" from RNA to DNA; hence their name. This fundamental characteristic of retroviruses means that they can become stabilised as part of the host genome, a phenomenon of considerable consequence for the treatment of HIV infection.

[2] Most genes, including HIV genes, code for several proteins. The translation product, a "pro-protein," is then cleaved into smaller proteins by an enzyme called a protease.

The virus reproduces itself by attaching to specific cells using receptors on the target cell surface, and injecting its genetic material into the cell. Once there, retroviral RNA is able to use the target cell's machinery to produce enzymes — *reverse transcriptase* (RT) and *integrase* — that then integrate it into the target cell's genome in the form of DNA. This means that HIV effectively becomes part of the host's genetic material, which makes it extraordinarily difficult to eliminate from the body. This is because to date drugs can only interfere with processes that occur at the level of proteins and enzymatic reactions.

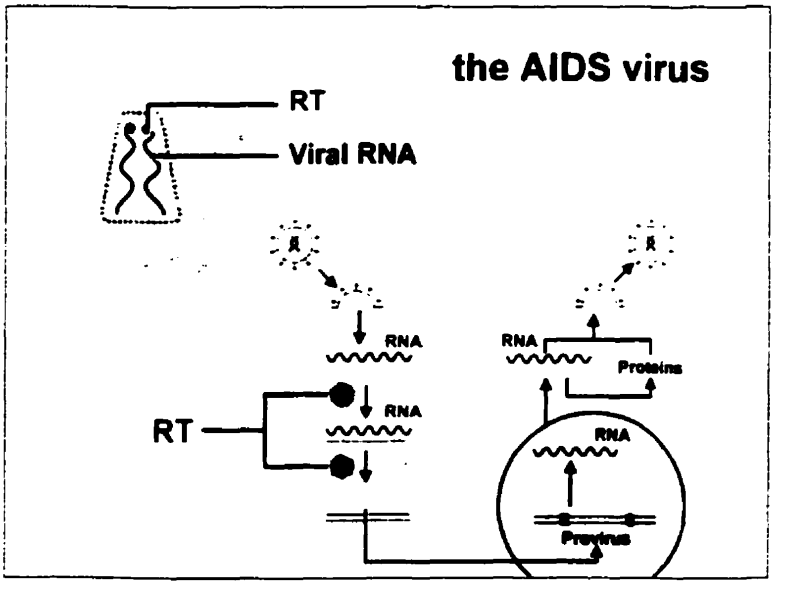


Figure 1.1 • Life cycle of HIV
(source: Sharp, Hoffman LaRoche http://www.haart.net/haart/dia/sharp/sharp2.htm)

Significantly, the enzyme by which the virus reproduces itself — reverse transcriptase — is particularly error-prone. This means that HIV does not copy itself very accurately into the host's genome, either by making transcription errors or by "reading off" different pieces of RNA to make the same piece of DNA, in effect producing a hybrid — or recombinant — viral sequence[3]. While doubtlessly these transcription errors lead to many copies that are not viable, they accelerate the evolution of the virus within a single host. This is one of the keys to this virus's success. By being error-prone in making copies of itself, HIV

[3] This high mutation rate, as well as a high recombination rate, is a general property of RNA viruses and explains why almost all new viral epidemics are due to RNA viruses (Burke 1998).

diversifies within the same host, in essence adopting many different disguises that make it easy for it to evade the host's immune response. The latter not only has a multiplicity of targets to chase down, but these targets are themselves constantly changing. This allows is to evade even the most robust of host immune responses, and to establish itself irreversibly in the host's genetic material.

As a result, HIV displays an astonishingly high degree of genetic diversity. Within the same host, that diversity is reflected in the existence of diverse quasi-species — discrete populations of viruses whose genetic differences can be used to cluster them into different groups. Figure 1.2 below shows the difference in viral diversity between a recently, or acutely, infected individual and one who has harboured the virus for a long time and is therefore chronically infected. Quasi-species are the result of the virus's evolution, which is driven both by its faulty replication mechanism and its host's immune response which is able to pick off certain viruses more easily than others. In this sense, we may say that the host immune response exerts selection pressure on the virus. The result is that the longer someone is infected, the more diverse their HIV will become, because it will have had that much more time to generate different quasi-species. This intra-host variability is paralleled in populations of hosts.

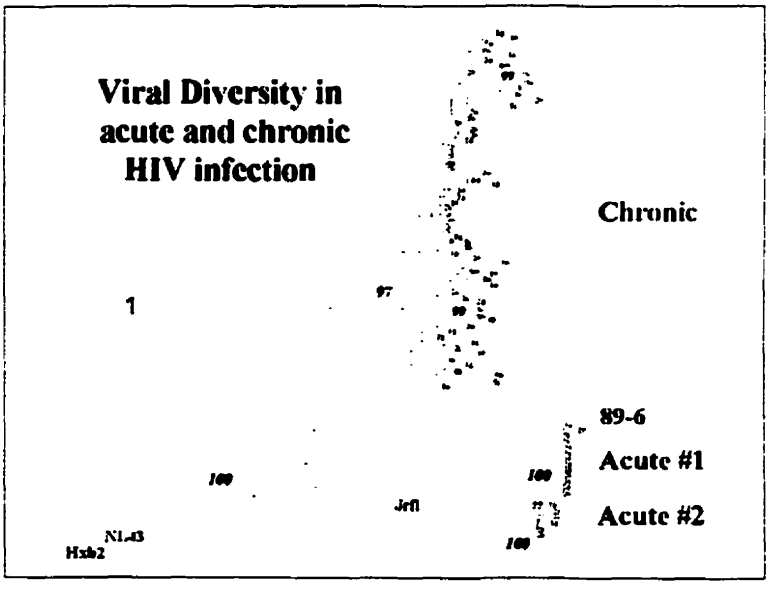
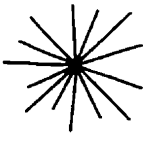


Figure 1.2 • Viral diversity in acute and chronic infection. Each horizontal line represents a genetically distinct quasi-species. From Walker, 2001.

The same two processes that lead to diversification within an individual — error-prone transcription and host immune response — are amplified as the virus circulates within a population that is by definition composed of many different hosts, each with differing immune responses. This increases the selection pressure driving viral evolution exponentially. This process of diversification has led to the creation of a number of subtypes of the virus, called clades. Diversification of the virus can be represented by a "starburst" diagram, with the original, ancestor virus represented as a point:

•

from which its descendants radiate in a starburst pattern:



Each line is equivalent to a family tree composed of viruses that share a common ancestor. Over time, each family tree branches out into subfamilies, with the branch points representing the ancestor common to subsequent descendents. The space between lines represents the genetic distance between individual viruses. However, the actual "map" of HIV genetic diversity is not symmetrical:

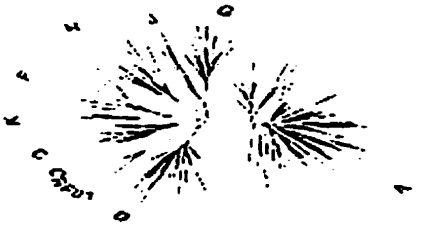


Figure 1.3 • HIV clades.

The starburst is not perfectly balanced. The gaps represent clades that never succeeded in establishing themselves; conversely, lines that extend out and become bushy represent reproductively successful organisms. While these organisms subsequently diversify considerably (represented by the "bushy" part of the diagram) these descendants will all be more genetically related to each other than to the descendents of other lines (the bushy extremities of the other

branches). As the diagram shows, these different clusters of descendants are grouped into subtypes, or clades, that are identified by a letter.

It is important however to underline that these diagrams are not accurate pictures of actual historical events. They are not, strictly speaking, genealogies. Rather, they are an attempt to reconstruct genealogy from genetic characteristics observed in contemporary organisms. Differences in these characteristics, taken to be represent divergences from a common ancestor, are used to extrapolate backwards to a common ancestor; in effect locating the branch points where strains diverged. (The science of classifying organisms this way is called cladistics, and is a branch of evolutionary biology called systematics. Formerly this was be done by looking at an organism's phenotype, or macroscopic characteristics. Nowadays it is done by looking directly at genetic sequences.)

Interestingly, there is a different geographic and social distribution for the different clades of HIV. Tracking these clades and their geographic distribution is the province of molecular epidemiology, and it has shed light on the origins and course of the epidemic. This story will be explored below.

Epidemiological methods in the study of HIV

Two methods have emerged as powerful strategies for tracking the epidemic in space and time. Epidemiological surveys rely on testing groups of individuals for antibodies to HIV. When these groups are identified according to standard criteria, they can be compared across different locations and at different times to give a picture of how the epidemic is evolving. Such groups, called "sentinel" groups, include pregnant women attending antenatal clinics (ANCs), individuals consulting sexually transmitted infection (STI) clinics or TB clinics, hospitalised patients, and groups considered to be "high risk" such as sex workers, truck drivers, men having sex with men, and soldiers. The ability to generate such sentinel seroprevalence data is conditioned by the local availability of testing infrastructure and the accessibility of catchment sites — such as antenatal clinics or tuberculosis treatment centres — to the population. These local variations constitute potential "selection biases" that would lead to different populations being surveyed in different areas and therefore to rates not being strictly

comparable across countries. However, with the proliferation of epidemiologic surveillance programs around the world, these biases are statistically controlled and can be made use of to paint a reliable portrait of the epidemic. Recent studies in America have used "tuning" — employing different HIV antibody tests with different sensitivities — to detect new infections. As this methodology is applied elsewhere, we can expect the epidemiologic picture to be further sharpened.

More recently, sophisticated laboratory techniques have been applied to epidemiological studies. Molecular epidemiology uses a variety of molecular biological techniques to identify variations in the genetic make-up of pathogens. These techniques detect genetic variation, either through enzymatic techniques[4] or molecular biological methods for isolating, amplifying and sequencing genetic material. This is an important tool for studying the distribution of genetic variants in space and time. These distributions are the product of the "natural" evolution of organisms as well as their "natural" tendency to reproduce and spread. The underlying principal believed to govern natural variation is of course the theory of natural selection, which holds that biological variation occurs randomly and that the environment exerts a "selection pressure" on that biological variation, such that only the fittest organisms survive. These new molecular studies demonstrate that neither evolution nor reproduction of pathogens are purely "natural," but are always already embedded in processes that are eminently social, and vice versa.

Evolution of pathogens such as HIV is the product of genetic mutation as well as genetic recombination. It can be recalled from the discussion above that HIV is a virus which is extraordinarily error-prone in replicating itself; this generates genotypic and phenotypic diversity ("quasi-species") within the host and is an effective strategy for escaping immune control as well as a powerful driving force of the virus's molecular evolution. Recombination of genes is another powerful driving force, and is a particularly significant element for error-prone retroviruses (Burke 1997). The high mutation rate is an evolutionary strategy where the disadvantages of high genetic variability are compensated by the advantages conferred by rapid diversification. Single mutations most often result in variants that are less fit than the original strain; multiple mutations must be acquired in order to achieve a strain that is as or more fit than the original strain. This is

[4] See the discussion of restriction fragment length polymorphism (RFLP) below.

somewhat analogous to typographic errors: one or two typos will be obvious mistakes, but if enough are accumulated a new word will result that may improve the meaning of the sentence in the context of its paragraph. This process can be visualised as a three dimensional landscape, known as the genetic "sequence space" (see Figure 1.4 below). Sequences that are on the peaks (the points on the top) represent fit viruses; as viruses mutate, they "fall off" the peaks. Recombination allows fit variants to shuffle genes, thereby allowing them to leap from peak to peak without falling into the valleys. In other words, "evolution can be thought of as the process whereby sequence space is explored, with successful variants colonising the fitness peaks... in rugged fitness landscapes [represented in Figure 1.4 below by steep hills and valleys], genomes only slightly removed from the local optimum may be totally unfit, so that exploration of the surrounding space becomes impossible. Recombination between genomes on separated fitness optima permits such an 'evolutionary broad-jumping' type of sequence space exploration; recombinant progeny may fall on previously totally unexplored fitness peaks" (Burke 1998:3).

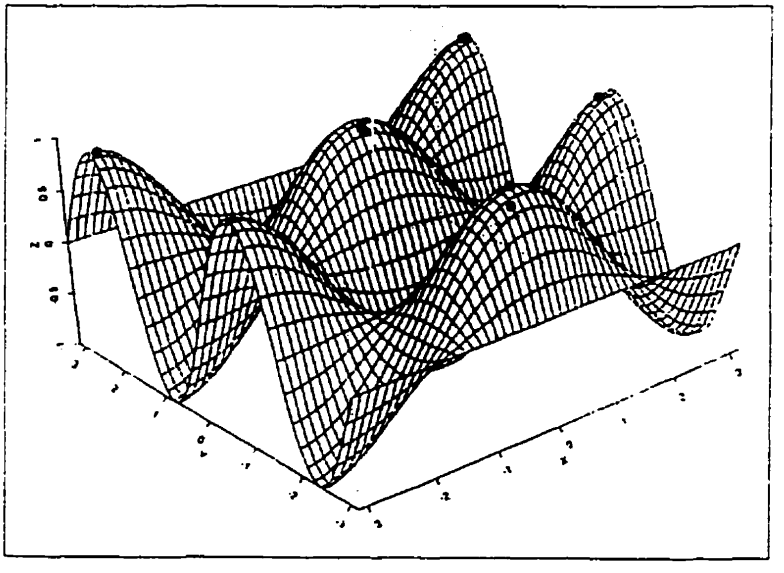


Figure 1.4 • Representation of a fitness landscape (Burke 1998: 3)

Thus, evolution is accelerated further when an individual is exposed to multiple strains over a short period of time. This situation can be expected to result in social settings where mobility and social networks lead to the circulation of multiple strains, behaviours such as sex and IV drug use allow for a high intensity

of transmission events over short periods of time, and social and ecological factors, particularly sexually transmitted infections (STIs), amplify the transmissibility of the pathogen. (STIs) amplify of HIV transmission for two biological reasons. Ulcerative diseases such as herpes cause mucosal breaks that increase exposure to HIV. Nonulcerative diseases lead to local inflammatory responses that increase the concentration of white blood cells in mucous membranes; these cells concentrate HIV in those who are already infected or supply ready targets for infection in those that are not.

The role of STIs has been documented by a wealth of studies, including the Mwanza study which showed that an intervention to aggressively diagnose and treat STIs reduced the incidence of HIV — the number of new infections — by over 40% (for a recent discussion, see Grosskurth 2000). Circumcision has also been identified as an important determinant of HIV epidemics in a number of studies, and randomised controlled trials are currently underway to assess the efficacy of circumcision as a prevention strategy. These factors have a *multiplicative* rather than a merely *additive* effect. Prevalence of STIs is high in settings where access to prevention education and interventions as well as curative biomedical services is compromised: poverty, warfare, and breakdown in public health systems are examples. These are settings that are associated with particular social conditions — political instability and rapid social change — that are related to configurations of power at both the "macro" (geopolitical and political-economic) and "micro" (cultural and gender) levels.

Molecular epidemiologic studies rely on the genetic characterisation of HIV strains found in circulation. "Molecular fingerprints," using restriction fragment length polymorphism (RFLP) techniques, sample fragments of viral genetic information to detect differences. RFLP, however, is unable to detect differences in genetic sequences that are not sampled (that is, do not contain "restriction sequences" or "break-points"). While it can detect recombinant viruses, those that contain genes from *different* strains, it is not a sensitive enough method to detect *intra*-strain recombinants, the kind that occurs most commonly. Advances in molecular techniques and computing power mean that sequencing of the entire HIV genome is now feasible. Although costly and time consuming, this method is much more

precise and allows detection of viruses that are the product of recombination *within* strains[5].

Molecular epidemiologic studies of HIV have demonstrated the emergence of recombinant strains in different parts of the world. When correlated with epidemiological and anthropological research, these studies have shown that these are areas where transmission is hyper-accelerated relative to 'normal' sexual transmission: essentially areas where intravenous drug use has become recent and is spreading rapidly. This makes sense, since the likelihood of recombination is increased when multiple strains co-exist in the same body, and this requires that a person be multiply exposed to different strains.

These recombinant strains are being sampled in Eastern Europe and Southern China, both of which have seen a surge in intravenous drug use. Speculation has linked this to the rapid pace of social change and state breakdown in these areas. This is an example of how situations of social breakdown, nutritional status and lack of access to preventive interventions — education, condoms and biomedical treatment for STIs — conjugate with massive population displacements and migration to fuel the progression of HIV epidemics. Combined with epidemics of drug use or rape — as is often the case in warfare — these conditions can cause explosive growth in HIV prevalence. Based on these observations, it may be hypothesised that large scale social forces accelerate and intensify viral evolution.

[5] These are referred to as *interclade* and *intraclade* recombinants respectively. Viruses that are recombinants or hybrids made of genes from different clades or families are different enough from each other that the restriction fragments will be of different lengths. A useful example would be to imagine a novel written out in one line on a single strip of paper. Using a literary restriction enzyme, we could cut the strip wherever the presumably rare word "uxorious" (a "restriction sequence" or site) occurred. This would give us strips of paper of varying length. If we applied our literary restriction enzyme to another novel, the fragments would be of different length. On the other hand, if we had several drafts of the same novel generated by cutting and pasting paragraphs within chapters, we could expect that many of these fragments would be the same length. So we would need to use another method — such as comparing strips of paper word-by-word — to know if they were truly different.

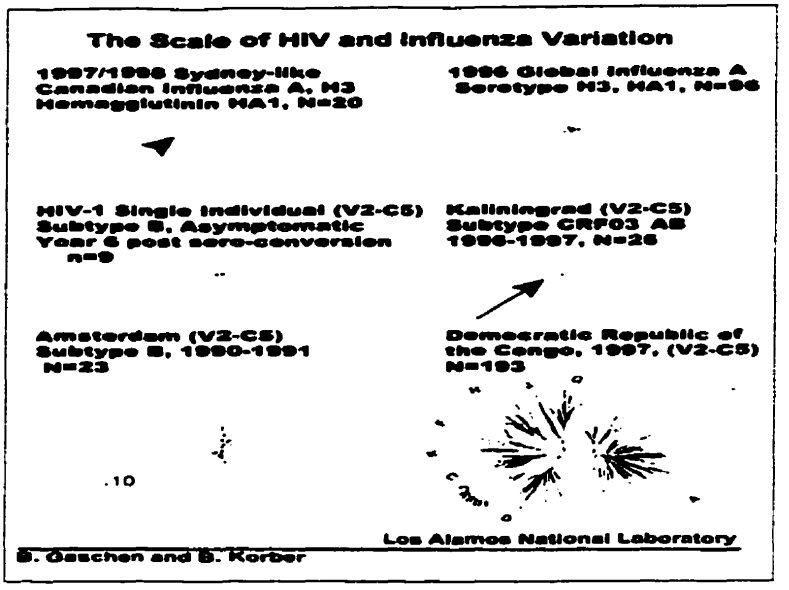


Figure 1.5 • Slide comparing the extent of diversification of influenza with the extent of HIV variation within one individual and within three sites: Kaliningrad (where an epidemic of a recombinant virus spread rapidly through IV drug use); Amsterdam (a recent sexually transmitted epidemic), and Democratic Republic of Congo (an established sexually transmitted epidemic). Slide courtesy of Geschen and Korber, from Walker, 2001.

The origins of HIV

There are currently three hypotheses to explain the origins of the HIV epidemic. All three of these hypotheses start from the observation that HIV's most immediate ancestor is SIV_{cpz}, a retrovirus found in chimpanzees that inhabit the forests of west-central Africa, in contemporary Gabon, Cameroun, Congo-Brazzaville (hereafter "Congo") and Congo-Kinshasa (hereafter "DRC", the Democratic Republic of Congo).

This observation is based on studies that have sampled retroviruses from humans and monkeys and sequenced key genes from them. Examination of genes using molecular methods can determine the genetic relatedness of retroviruses (as well as other organisms) by seeking "sequence homologies," that is, identical stretches of genetic code[n]. The more sequence homology, the closer two genes are to their

[n] Genes are sentence-like messages, made up of letters (nucleotides) strung together in words (codons); these words are 'read' by cellular enzymes and 'translated' into amino acids that are then assembled into proteins.

common genetic ancestor. Using the phylogenetic methods described above, these studies have sampled existing HIV strains in order to identify that their most likely common ancestor was SIV. SIV is believed to be an old virus, as it is found both in the *pan troglodytes troglodytes* and *schweinfurtheii* chimpanzee species. These species have distinct geographic habitats, *troglodytes* chimps living in West Central Africa and *schweinfurtheii* in East Central Africa (highlighted in Figure 1.5). They are believed to have diverged thousands of years ago. Presumably, their common ancestor species was the original host of SIV_{cpz}.

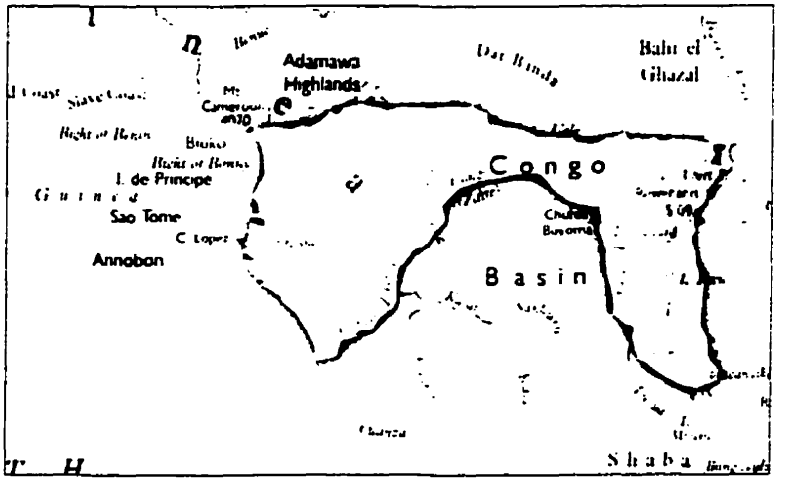


Figure 1.6 • Geographic range of chimpanzee subspecies; *pan troglydytes troglodytes* on the left, *schweinfurtheii* on the right (from Sharp)

Thus, HIV, like most other infectious diseases of humans, was a zoonotic epidemic. Chimpanzees were the primate reservoir from which HIV arose. All three of the origin hypotheses posit a different explanation for how SIV was (i) transmitted to humans and (ii) spawned an epidemic caused by HIV. The "natural transfer" theory hypothesizes that humans were contaminated by the chimpanzee virus through routine contact with their bodily fluids, most likely through the butchering and consumption of bushmeat. Such practices are held to have intensified in the Belgian Congo during the interwar period, when forced labour practices implemented under colonial rule led to widespread migration and famines. At that time, both French and Belgian Congo were run as concessions, rented out to private companies that ruthlessly exploited native labour to build railways and extract rubber and timber from the colonies. Epidemics of sleeping sickness, malaria and other tropical diseases took a heavy toll on the colonies, with astonishingly high mortality rates. It is estimated that during this period, up

to a third of the African population of the colonies may have perished (cite AIDS paper). The theory is supported by molecular studies of HIV's genetic diversity, that use a "molecular clock" method to estimate when contemporary HIV strains would have diverged from their common SIV ancestor. This method has identified the period around 1931 as the most likely time the virus diversified. This diversification observed in SIV genes is assumed to correlate with the triggering of an epidemic in humans around that time[7].

Two rival theories dispute the "natural transfer" theory's assertion that a "cut hunter" was enough to trigger the epidemic (Chitnis 2000, Yusim et al 2001). One of these has garnered widespread media attention since the publication of an extensively researched book by British science journalist Edward Hooper (1999). This theory argues that mass inoculation of over a million Africans with an experimental oral poliovirus vaccine (OPV) in the 1950s was responsible for contaminating a large number of humans with SIV. According to the OPV theory, this vaccine was contaminated with SIV because some batches were prepared using chimpanzee kidneys as a culture medium. Hooper found that the earliest recorded cases of HIV were geographically clustered in areas where the experimental vaccine had been administered. Poor record-keeping on the part of the vaccine's developers has made it difficult to counter Hooper's assertion.

However, the OPV theory has been vigorously contested. Hooper's proposed timing (the 1950s) does not mesh well with that suggested by molecular studies, which indicate that the HIV ancestor virus (aptly named the "Eve" virus) diversified around twenty years earlier. However, these molecular studies do not indicate whether this diversification occurred in humans or chimps and do not, in and of themselves, refute the OPV hypothesis. They only indicate that OPV would have had to transmit a variety of genetically different strains of HIV. The vaccine's developers have adamantly denied that chimpanzee cells were ever used in the manufacture of the vaccine; furthermore, it appears that even if this had been the case, SIV would not have survived the processes used to develop the vaccine (Lena and Luciw 2001). Finally the geographic correlation of early AIDS cases with vaccination sites could be an ecological fallacy, a coincidence explained by

[7] However this does not rule out that SIV could have been transmitted to humans earlier than 1931 only to diversify later (zoonotic transmission preceding an epidemic); or, alternatively, that the epidemic occurred late after zoonotic transmission.

the fact that whatever AIDS cases were present at the time were more likely to have been reported by medical dispensaries that were also used to administer the experimental vaccine. Hooper did not look for AIDS cases in areas where the vaccine was not administered.

A different theory has been advanced by the New York primatologist Preston Marx in collaboration with Ernest Drucker, an epidemiologist at the Einstein College of Medicine in the Bronx. Marx's research has concentrated on another SIV, that found in sootey mangabeys in West Africa (SIV_{sm}).

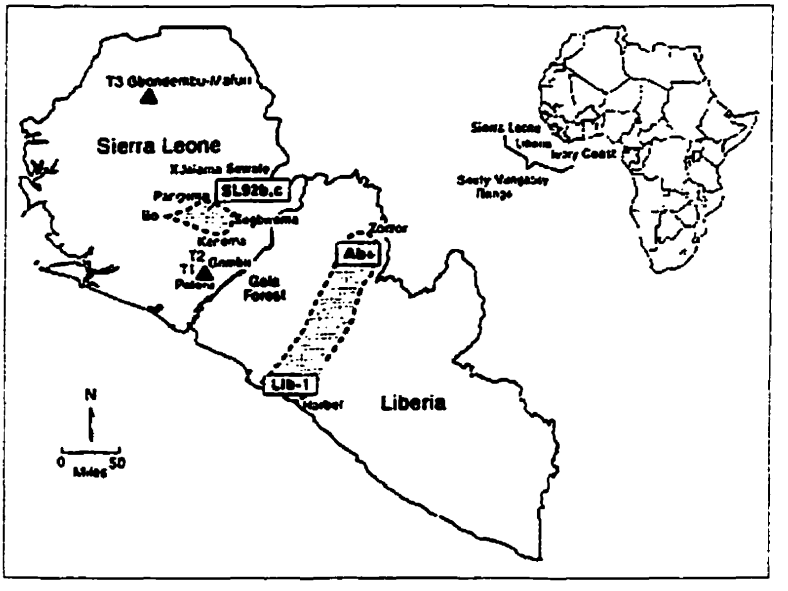


Figure 1.7 • Geographic distribution of sooty mangabey monkeys; area of Liberia where Marx sampled sooty mangabey monkeys for SIV_{sm} is highlighted (Chen et al 1996:3619)

SIV_{sm} appears to be the ancestor of HIV-2, another human retrovirus found in West Africa that is both less infectious and does not appear to cause as severe disease in humans as HIV-1. Marx and his collaborators found that transmission of SIV_{sm} was an extremely unusual occurrence amongst Africans who had SIV_{sm}-infected monkeys as pets (Chen et al 1996); this "natural transfer" rate appeared to be too low to explain an epidemic. Marx and Drucker hypothesised that such rare cross-species infections could be amplified by serial passage of SIV to humans from an original monkey-infected human through the re-use of needles. Not only would this explain how larger numbers of people could be contaminated, but

serial passage would account for SIV's mutation into a more virulent HIV strain[*]. In addition to widespread anecdotal evidence that the re-use of needles was common throughout Africa in the postcolonial period — indeed, as late as the late 1980s — Marx and Drucker have collected data showing that the exponential increase in the worldwide use of needles preceded the decrease in the unit price to support their "re-used needles" hypothesis (Marx, Alcabes and Drucker 2001).

All three of these hypotheses — "natural transfer," OPV, and re-used needles — locate the origins of the epidemic in social changes occurring in Africa during the colonial and postcolonial periods. The natural transfer theory argues that migration and urbanisation broadened and intensified sexual networks sufficiently to trigger an epidemic that until then had never reached a threshold of contamination that would have allowed it to spread beyond the bush where the "cut hunters" lived. Both the OPV and re-used needles theory incriminate the dissemination of biomedical practices — vaccine trials and increased use of injectable drugs — in the spread of the epidemic. Shifts in disease ecology would also play a role in all three hypotheses. Other sexually transmitted infections (STIs) — such as gonorrhea, chlamydia, genital herpes, or trichomonas — increase the transmissibility of HIV considerably. Malnutrition and the presence of chronic diseases such as sleeping sickness or tuberculosis are assumed to increase susceptibility to HIV — indeed, this may be an important explanation for why the poor are more susceptible to HIV. All of these biological factors were also concurrent with the social changes wrought by colonialism: some STIs are believed to have been introduced by Europeans, and concentration of male workers in workcamps encouraged prostitution, furthering their spread. In addition, ecological changes caused by resettlement of villages and disruption of traditional agricultural patterns precipitated famines and epidemics of sleeping sickness (Lyons 1992). Mobile public health campaigns reused needles both to diagnose and to attempt to treat the disease. It has been reported, for instance, that between 1917 and 1919 only six syringes were used to vaccinate up to 90,000 in Ubangui-Chari (now the Central African Republic) and that UNICEF dispensed over 12 million injections of penicillin in a campaign to eradicate yaws between 1953 and 1957 (Carlsen 2001).

[*] Serial passage of a pathogen through successive hosts exerts a selection pressure for more virulent strains.

The OPV hypothesis, despite powerful circumstantial evidence, has been considerably weakened because of its biological implausibility (the inability of SIV_{cpz} to survive the vaccine preparation process) and the molecular studies of the virus cited above that locate diversification of HIV prior to the OPV trials Hooper has incriminated. The growing credence of the "natural transfer" theory does not, however, exonerate the reuse of needles as playing a major part in the epidemic. Further molecular studies have identified a burst in the diversification of HIV in the 1950s and 1960s; this evidence would support both the OPV and reused needles hypotheses. Re-used needles are currently being collected by Marx and collaborators in Cameroonian clinics to test the serial passage hypothesis (Carlsen 2001).

Beyond the controversy over the origins of the HIV epidemic, consensus lies around the complex interplay of biological and social factors that all three of these theories — and the sophisticated scientific evidence marshalled to support them — implicate. Interestingly, all three of these theories discount individual sexual behaviour as being the key to understanding the origins of the epidemic. This corroborates emerging epidemiological evidence that sexual behaviour does *not* appear to explain differences in epidemic proportions in different cities in Africa.

A landmark study comparing two low-prevalence cities (Cotonou, Bénin and Yaoundé, Cameroon) with two high-prevalence cities (Kisumu, Kenya and Ndola, Zambia) concludes that "differences in the rate of HIV spread between the East African and West African cities studied cannot be explained away by differences in sexual behaviour alone. In fact, behavioural differences seem to be outweighed by differences in HIV transmission probability."[9] By this, the authors refer to differences in rates of STIs and circumcision in the two cities. One caveat that needs to be kept in mind, however, is that epidemics are not static, but evolve over time, and that different factors — such as behaviour or transmission probabilities — may contribute with a different force at different stages of an epidemic's maturity.

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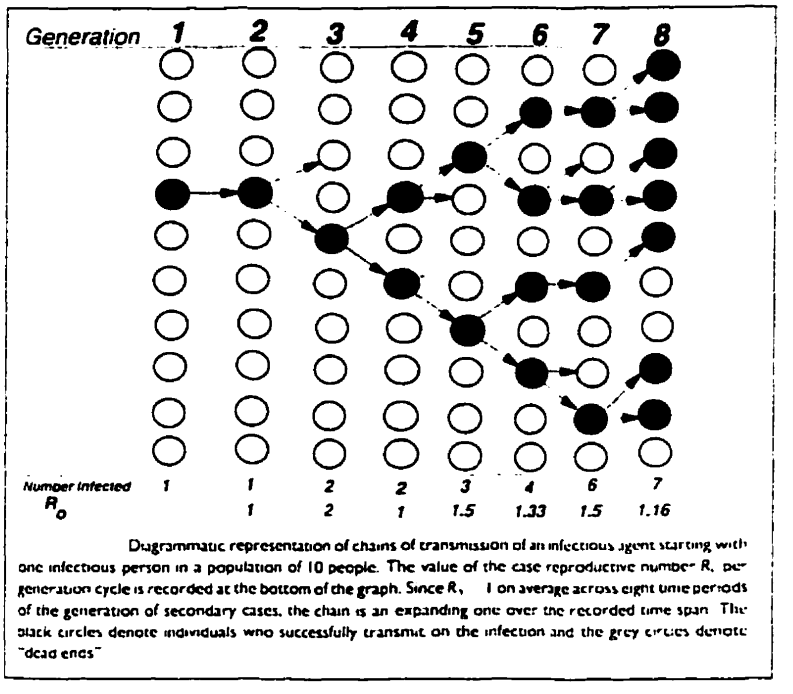
[9] The report of the study conducted by Buvé et al, can be consulted at www.unaids.org/publications/documents/epidemiology/determinants/lusaka99.html#findings (accessed 17 September 2000) and has been submitted for publication.

The complexity of these factors deserves explanation. An epidemic will "take off" if R_0, the parasite's basic reproductive rate, is greater than 1. R_0 is the product of three factors: the rate of partner change (in other words, the number of individuals exposed to an index case over a period of time), the transmissibility of the infection, and the duration of infectiousness of the index case.



Diagrammatic representation of chains of transmission of an infectious agent starting with one infectious person in a population of 10 people. The value of the case reproductive number R_0 per generation cycle is recorded at the bottom of the graph. Since R_0 > 1 on average across eight time periods of the generation of secondary cases, the chain is an expanding one over the recorded time span. The black circles denote individuals who successfully transmit on the infection and the grey circles denote "dead ends"

Figure 1.8 • Representation of R_0 (Anderson 1998:33)

The actual dynamics are quite complex. For instance, individuals with HIV are most infectious during seroconversion; that is, in the few weeks following their being infected, when their immune system has not yet had the time to mount an effective immune response and the quantity of virus in the blood (the "viral load") is highest. Thus, it is not only a question of *how many* partners, but *when* these partners are being exposed, in addition to multiplicative factors like the presence of other STIs. The chance that an individual's exposed partner is HIV+ also influences the success of prevention interventions. This chance is higher in high prevalence settings than in low prevalence settings. Prevention interventions are never 100% effective, but any drop in efficacy (such as a drop in condom usage) is more dangerous in a high prevalence setting — where there is a significant

chance that one's partner may be infectious — than in a low prevalence setting, where the occasional lapse does not incur much risk.

However, prevention efforts have almost exclusively concentrated on changing individual behaviour without addressing either the social factors that condition that behaviour or ecological factors that may affect transmission probabilities such as overall seroprevalence rates or the prevalence of STIs. Surprisingly, few comparative epidemiological studies have sought to identify how different concatenations of these biological and social pathways result in different epidemics. For example, in the four-city study cited above, hypothesised differences in variables such as sexual behaviour patterns were unexpected, suggesting that the quantitative data gathered — based on formal questionnaires that focussed on quantities and types of partners and frequencies of sexual intercourse — may have been unable to capture important qualitative factors. My study is designed to overcome this gap, by examining the case of Abidjan, in Côte-d'Ivoire.

Abidjan is considered the epicentre of the West African HIV epidemic — the city had early on the highest rates of HIV as well as the highest mortality. Through the 1980s, seroprevalence rates skyrocketed, and by 1989 AIDS was authoritatively demonstrated to be the leading cause of death of young men (De Cock et al 1989). At the time, there was a dearth of epidemiological data on HIV in West Africa, particularly from Nigeria, so that it was possible to attribute Abidjan's leading HIV rank to a reporting bias that reflected more the high concentration of HIV research projects in the city than to any essential regional difference. Since then, however, the picture has emerged consistently that seroprevalence rates, morbidity and mortality are highest here, even compared to the only city that is larger in the area, Lagos in Nigeria.

The current national seroprevalence rate of adults in Côte-d'Ivoire is estimated at 10,76% twice that in Nigeria. However, rates in Abidjan are higher and informal estimates I collected from interviews with local clinicians and epidemiologists range from 15 to 20%; 13% of women attending antenatal clinics in the city are positive. This contrasts markedly with Sénégal, further west along the coast. That country has recently been touted as a success story for AIDS control, as an epidemic never took off. Adult seroprevalence is estimated at 1,77%; the rate in

antenatal clinic attenders in the Dakar metropolitan area is even less at 1%. An intermediate case is in Burkina Faso where epidemiological figures are sketchier, given its poor health care infrastructure and capacity for epidemiologic monitoring. However, current estimates peg the adult seroprevalence rate for the country at 6%, which is also the rate for women attending antenatal clinics in major urban areas (Ouagadougou and Bobo-Dioulasso)[10]. Interestingly, one retrospective serological survey detected no cases of infection prior to 1986.

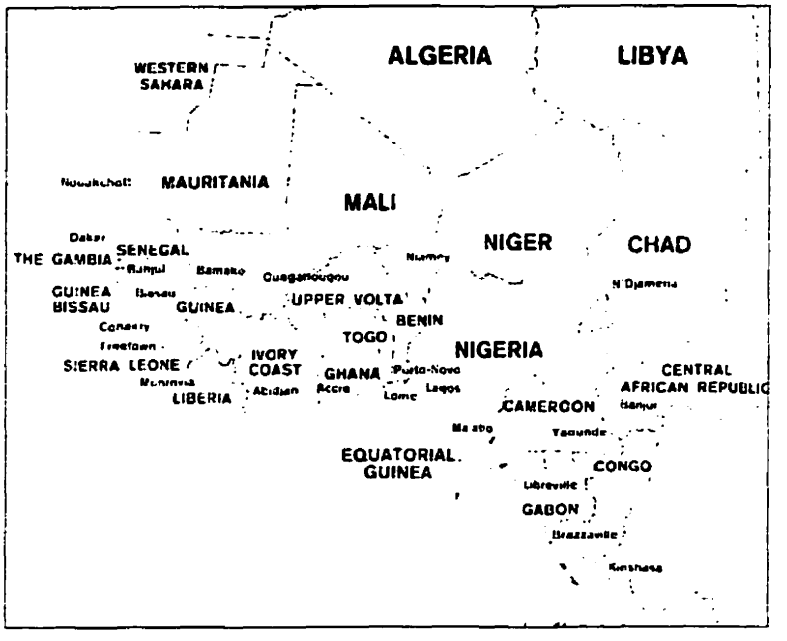


Figure 1.9 • West and Central Africa, showing population densities (darkest areas most densely populated).

This seroprevalence gradient correlates with molecular biologic studies of the genetic diversity of the virus. These have documented a diversity gradient, with diversity greatest to the east in the Democratic Republic of Congo (DRC) and least to the west in Sénégal (Peeters, personal communication). Genetic diversity correlates with maturity of the epidemic, and such studies corroborate epidemiologic evidence that the epidemic started in Central Africa. Progress of the epidemic is monitored through serial seroprevalence surveys of "sentinel groups" such as pregnant women attending antenatal clinics, and patients consulting with sexually transmitted infections or tuberculosis. Such surveys, along with a few

[10] All figures are from country surveys reported annually by UNAIDS; these are most easily available on http://www.unaids.org

retrospective surveys of stored sera sampled in the past, confirm this molecular data on the progress of the epidemic from east to west. Interestingly, while the epidemic exploded in the eighties in the Ivoirian metropolis of Abidjan it appears to have levelled off in Kinshasa, its central African urban epicentre, and never took off in Africa's westernmost major city, Dakar, where seroprevalence rates are lower than in some US populations[11].

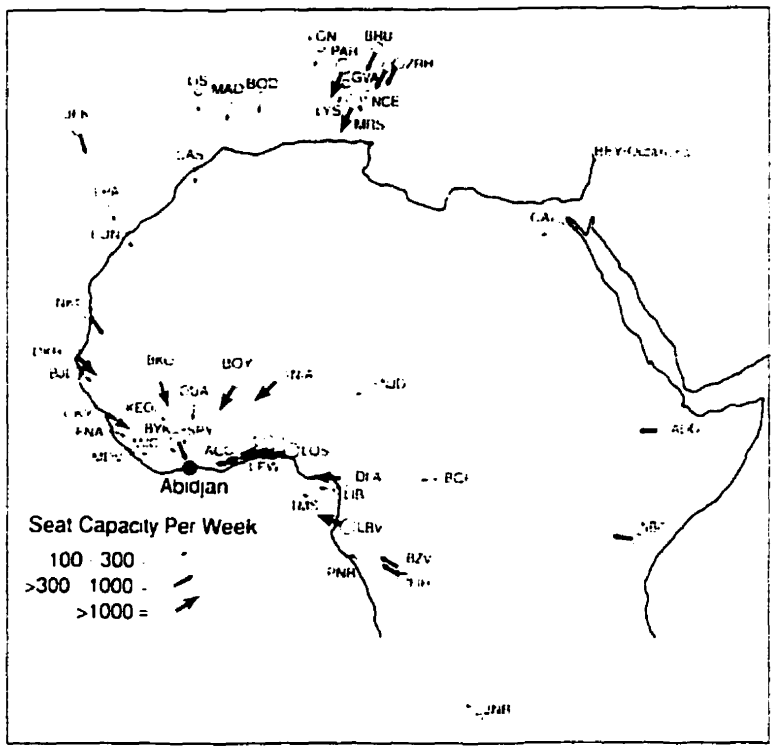


Figure 1.10 • "Abidjan, the capital of the Ivory Coast, as the focus of direct flights in a piece of the international air network. The city is highly connected in the international backcloth, allowing both varieties of HIV to be transmitted quickly." (Gould 1996)

How to explain these differences in the epidemic's evolution? The Abidjan epidemic has been attributed to steep social inequality during the years of the "Ivoirian miracle", when the city was the hub of exchange in West Africa, money was easy and the streets were lined with call-girls (Gould 1996[12]). Abidjan's "hub" status can be seen in Gould's map of airline seat capacity, a measure of capital flows and moneyed migration (Figure 1.10). In this vein, the role of prostitutes has been repeatedly invoked. While this explanation may seem unpalatable

[11] Seroprevalence rates in women attending urban antenatal clinics (ANCs) have remained stable at 6% in Kinshasa and under 2% in Dakar, while in Abidjan they skyrocketed to nearly 13%.
[12] Gould's evidence for prostitution as a factor is anecdotal.

because it singles out of prostitutes as vectors of the epidemic, it is also far too simplistic. Such gradients — as well as call-girls — existed elsewhere at the time: most notably in Nigeria. Yet the epidemic there, by all indications, has not achieved the same magnitude. Epidemiologists have pointed to the role migration plays, in addition to social inequality, and gender, in the spread of the epidemic. These factors must be taken into historical perspective in order to get a fuller picture of why Abidjan emerged as the epidemic's West African epicentre. This will be the subject of the next six chapters.

Chapter 2
Colonial government and urban origins

Introduction

As discussed in the introduction, this dissertation argues that careful empirical study of the epidemic indicates that there is no "independent" variable — be it society, culture, or political economy — against which the geography of the epidemic can be plotted. Rather, these must be considered co-variables of biological change. Consequently, the dissertation examines these phenomena — epidemics, society, culture, political economy — as particular crystallisations of biological and social changes. Beginning with the colonial history of Abidjan is not meant to offer a neat account of the historical origin of the epidemic. Rather it offers a picture of how society and biology co-produce each other. By concentrating on the material dimension of urban space, it is possible to see how biology, registering as the experience of disease, representations of aetiology, and their application in urban planning, was co-produced along with social relations. This "co-production," as will be shown in later chapters, persists through to the present. Historically sedimented in the urban contours of the city and the social apparatus for intervening on human biology, this coproduction laid down the pathways through which subsequent bio-social change would unfold.

Thus, social relations and urban culture in contemporary Abidjan cannot be considered in isolation of the historical circumstances of which they are a product. This consideration shows that the predicament of colonial conquest — the assertion of colonial power over a heterogeneous zone populated by a

diversity of societies — crystallised in the creation and development of the city. In the case of Abidjan, urban experience was produced through the sublimation of colonial conflict. This conflict produced a special kind of urban space and was also manifested in attempts to govern the numerous people who gravitated there in search of a better life in the new colonial economy. These contours of urban space, and the accumulation of practices — the rules, ordinances and routines of colonial government — aimed at governing the coexistence of Africans and Europeans, persisted long after the difficulties and incidents that brought them into existence had resolved or simply faded away.

These material processes continue to shape urban life in Abidjan to this day, a legacy of colonial modernity. One could argue that the material configuration of any city — neighbourhoods, monuments, civic buildings, public spaces — should be viewed as a metaphor for contemporary urban social life. Monuments and buildings, even the lay-out of neighbourhoods are residues of past decisions, events and struggles that continue to be negotiated in contemporary, everyday existence, unmindful of their at-times laden past; yet these structures shape the behaviour, itineraries, and indeed the experiences of today's urban dweller. Here, this argument is pushed further, by arguing that social practices in colonial Abidjan — the segregation of natives from settlers, the bureaucratic routines invoked to manage the population, and so on — are just as material as are the concrete and reinforced steel that make up the structures of the city. The term "material" indicates that these social practices are as constraining and constitutive of behaviour, itineraries, social networks, and experiences as are buildings, roads or neighbourhoods.

In making this argument, this account differs from other approaches to colonial cities in Africa, which have stressed urbanisation as a necessary prelude to modernisation (Miner 1967, Rayfield 1974). Others have drawn on a Marxist narrative, whereby colonial cities, considered "theatres of accumulation," were key points in a world capitalist system, assuring relations between a hinterland that was the source of primary materials and labour, and the "metropole,[1]" or colonial motherland. There, these products were used in capitalist production and re-sold

[1] The term *metropole* is used in French to refer to the colonial motherland — in this case, France. A growing body of historical work — e.g., Cooper and Stoler 1997 — has adopted this usage in English and I use it in this sense here.

back to colonised populations, transiting once again on their return through port-cities. The colonial city was thus a hub, or perhaps more accurately, the pivot of an emerging capitalist economy, a site of extraction of both wealth and labour from subjugated populations. Development of colonial infrastructure led to partial "proletarianisation" with the emergence of an urban, African working-class[2].

Writing largely from a South Asian perspective, historians associated with the "subaltern studies" school have chastised both these approaches for reading history through the prism of European categories, such that postcolonial societies are always seen to be playing "catch-up" to a unitary Euroamerican modernity. In addition, they argue, these histories either flatten native (subaltern) agency through the prism of class consciousness or romanticise peasant resistance by attributing agentive coherence where there was none (Guha and Spivak 1988). The issue of "native agency," colonial modernities and engagement with a globalised present will be explored throughout this dissertation and particularly in chapter 3, while remaining mindful of larger structural forces that do, indeed, constrain agency.

Certainly, modernisation and integration into a global political economy were hallmarks of the colonial period. These issues determined the shape the city was to take: its geographic layout, types of neighbourhoods, the distribution of different types of housing and the infrastructure that underlay them, and the articulation of public and private space. These elements, whether visible (as buildings, roads, monuments, parks) or invisible (sewage, plumbing, electricity) constitute the *spatial* dimension of the city. They register at the level of urban dwellers' experience, as the spaces they move through, imagine, or experience. The contrast between life in a well equipped villa atop a breezy hill surveying the city, and life in a crowded *cours commune*[3] where one gets water from a tap on the street outside, and the physical space that one must cross between the two, is one example. Space acts as the substrate of urban experience, channelling everyday life in particular ways and differentiating forms of sociability. The chatter and play

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[2] See Cooper 1983, Coquery-Vidrovitch 1991, De Brune 1985, King 1985, Mabongunje 1990, Simon 1989.

[3] Literally, "shared courtyard", which refers to a popular type of housing arrangement with single story rooms opening onto a shared courtyard which doubles as kitchen, workspace and entertainment area.

that occurs around a communal tap, the jealousies and solidarity that play out around a shared courtyard, the patterns of gossip and rumour that circulate through neighbourhoods, are all conditioned by these material forms, analogously to the way chemical reactions result from the Brownian motion of elements in a solution. This chapter focuses on the origins of this substrate and its materialisation in the lives of urban dwellers. As we shall see in subsequent chapters, this material substrate furnished the elements out of which a modernist society and an urban culture would arise after the colonial period.

Figure 2.1• Life around a communal water pump in Treichville, 1959 (Diabaté, n.d.).

The *production of space* furnishes the framework of analysis of this chapter. Considering space — housing, geography, embodiment — as produced rather than given allows us to ask *how* space was produced, going beyond phenomenological description. Phenomena which would otherwise be accounted for separately — urban planning, architecture, political economy, culture, everyday urban life — can be treated together. This view shares affinities with Durkheim's sociological epistemology, against Kantian views that see space as pre-existing social relations. However, the intention is not to ontologise society by treating space as a "total social fact." The notion of the production of space identifies its historical contingency, but also to its role in the production of social relations; space is thus both base and superstructure, in Marxist terms:

> Space is never produced in the sense that a kilogram of sugar or a yard of cloth is produced. Nor is it an aggregate of the places or locations of such products as sugar, wheat or cloth. Does it then come into being after the fashion of a superstructure? Again, no. It would be more accurate to say that it is at once a precondition and a result of social superstructures. The state and each of its constituent institutions call for spaces — but spaces which they can then organise according to their specific requirements; so there is no sense in which space can be treated solely as an *a priori* condition of these institutions and the state which presides over them. Is space a social relationship? Certainly — but one which is inherent to property relationships (especially the ownership of the earth, of land) and also closely bound up with the forces of production (which impose a form on that earth or land); here we see the polyvalence of social space, its 'reality' at once formal and material. Though a product to be used, to be consumed, it is also a means of production; networks of exchange and flows of raw materials and energy fashion space and are determined by it. Thus this means of production, produced as such, cannot be separated either from the productive forces, including technology and knowledge, or from the social division of labour which shapes it, or from the state and the superstructures of society.
>
> Lefebvre 1991 (1974):85

I was drawn to this approach because it paid attention to the largely accidental material constraints that impinge on everyday urban life in the city in general, and everyday sociality in the African city in particular, while remaining agnostic about the existence of *a* society. In this it paralleled my own experience of living in Abidjan and the way I came to understand how social relations there were constructed; this view has also informed the work of much of the French social science literature on Abidjan (see particularly chapter 4). In addition, as we shall see, the colonial context is precisely one where the concept of a society is inaccurate, and would gloss over highly differentiated terrains of domination, struggle, resistance, creativity and play. The emphasis on space allows attention to be paid to the mobility of actors that is so characteristic of the African colonial and postcolonial experience. This mobility draws together village and town as the early anthropologists of the Rhodes Livingston Institute showed (Werbner 1984), but also spans across, and ties together, different cultural worlds, social relations, moral economies, therapeutic systems, and modes of production. Mobility spans bodies, ideas, and practices. In the Ivoirian case, mobility was initially driven by colonial policies and the entry of the territory into the global capitalist economy, but in turn it created new forms of colonial subjectivity. "Natives" were able to

turn mobility to their advantage and use colonial state policy for their own ends (see Chapter 3).

The production of space thus allows historical inquiry that is genealogical in method, a tracing-back of historical circumstances that have been threaded together without the guidance of a teleological historical agent. Furthermore, as mentioned above, the materiality of space furnishes a ready metaphor for understanding why the material practices of the state — identity cards, housing regulations, censuses, vaccinations — take on an everyday importance that is, at first blush, out of proportion with their intended significance. As these chapters will argue, it is precisely these material practices that are productive of social relations and extend the horizons of agentive possibility. This approach opens the way, then, to an archaeology of everyday life (Foucault: 1986) and, through the consideration of material practices of housing, mobility and modernisation, an Archimedean point from which social change and its mediation can be examined.

Historians have debated the extent to which African cities can be said to have existed in significant fashion before they became colonial cities; in the case of Abidjan, there is clearly no urban tradition which preceded it prior to the colonial period when it was founded in 1903. This is unlike surrounding colonial cities — Freetown, Monrovia — that had come into existence in the nineteenth century or, as in the case of Saint-Louis (Sénégal), even earlier. Accra, Bobo-Dioulasso, Ouagadougou, Lagos, Kano, Oyo, Ibadan, Djenne, Kumasi, Porto-Novo and other similar towns had been important precolonial urban centres. However, only in Kumasi and Porto-Novo do vestiges of these original towns remain, the dismantling of older cities having been a systematic colonial practice (Winters 1982). As a result, it is in the social changes of the colonial period that the origins of contemporary urban life in Africa have largely been located. In this consideration of Abidjan, the following four sections will examine (1) hesitations over the location of the colony's future capital, (2) colonial land tenure, (3) concerns over settler health and (4) the political economy of colonisation.

A brief historical overview: territorial conquest and the location of the capital

The French attempted to consolidate their presence on the coast of the Gulf of Guinea in 1843, by fortifying privately established coastal trading posts (*comptoirs*). In the wake of the abolition of the slave trade, the fortified *comptoirs* were set up as an experiment, destined to develop local agriculture along the coast, which would allow natives to trade for imported goods, thus creating new markets for French products. The French negotiated with local villages, paying tribute for the land on which the *comptoirs* were built in exchange for trade monopolies. It was believed trade would pave the way for asserting a French presence in the face of its perennial rival, Great Britain, whose merchant navy was already well established along the coast, harbouring in similar fortified settlements at Cape Coast (Ghana) and Lagos (Nigeria). However the French experiment failed. Local agriculture never developed much and even French traders sold more English and American goods than French products, the former being preferred by the natives. The French did however gain a grudging acceptance, having made up for inexperience by conducting trade through middlemen: Sierra Leonean, Liberian or Ghanaian mulattoes — Africans who had been *boys* (domestic servants), or who had been to missionary schools elsewhere (the first missionary school not being established in Côte-d'Ivoire until 1886; see Harding 1971). While the middlemen's ability to negotiate both African and European habits were useful in building up commercial ties, the French arrived too late and were unable to displace trading relationships already forged between the British and the Africans. The *comptoirs* did not generate enough revenue to pay for the military presence, and in 1871 they were abandoned (Atger 1962:61).

Figure 2.2 • West Africa, 1890. The Ivory Coast comprises the area between Cap Palmas at the Eastern tip of Liberia and Assinie, on the border of the British Gold Coast. Note that the interior is labelled by the term "Mandango" and "Ashanti," referring to the polities of that name.

This marked the transition to an era of "unprotected trade." The French presence was reduced to "wily" traders who stayed behind, some of whom became quite successful. However a shift in the political context in metropolitan France reversed the original doctrine that had led to the establishment of the *comptoirs* half a century later, and now put sovereignty *before* trade. It was in light of the new emphasis on sovereignty that one of those successful traders, Verdier, was named the first resident French representative in 1878. The lush vegetation of the coast encouraged Verdier to nurture fantasies of tropical abundance: the tropical climate would assure a bounty of exotic fruits, artificial prairies would allow cows, goat and pigs to graze, and vegetable gardens would round out the production to satisfy the French palate tinged with a taste for the exotic. Stymied by profuse overgrowth and rapacious insects, like many colonial fantasies his dream never came to fruition, and his exports remained largely confined to gold and palm-oil. However, Verdier's brother, the French Consul in Cape Palmas, had planted coffee which fetched a lucrative 2 francs a kilo on the Paris market in 1881.

Seeing in his brother's experience an opportunity, Verdier obtained a monopoly on coffee culture that year. The monopoly was never recognised by the Minister for the Colonies, but Verdier's endeavour pioneered what would become, half a century later, the colony's leading export (Atger 1962).

The logic of asserting sovereignty, particularly in the face of an expanding British presence, led to the juridical establishment of the colony in 1893. The French claim to the territory was reinforced by missions to the interior led by French explorers, such as Treich-Laplène, who followed rivers up-country in a quest to map the interior. Binger (Figure 2.3) was named Governor of the new colony and its capital was located in Grand-Bassam, one of the original fortified trading posts with a large French trading community. Bassam was located at the confluence of the Comoé river and the Ébrié lagoon, offering a natural hub for connecting commerce between the interior and sea-going vessels. When it became the capital of the new colony, only a narrow strip of land along the ocean was effectively under French control: the remaining territory existed only as an empty space on maps (see Figure 2.2). In order to implement French sovereignty over the unmapped territory, Binger followed a policy of "peaceful penetration", attempting to conquer the interior through a series of missions empowered to negotiate the imposition of French rule. Peaceful penetration was a failure, punctuated by armed revolts, and requiring French intervention which was far from peaceful. By 1908, when the Governership was assumed by Angoulvant, the territory of the colony was still not under French control.

Figure 2.3 • Governor Binger on the left.

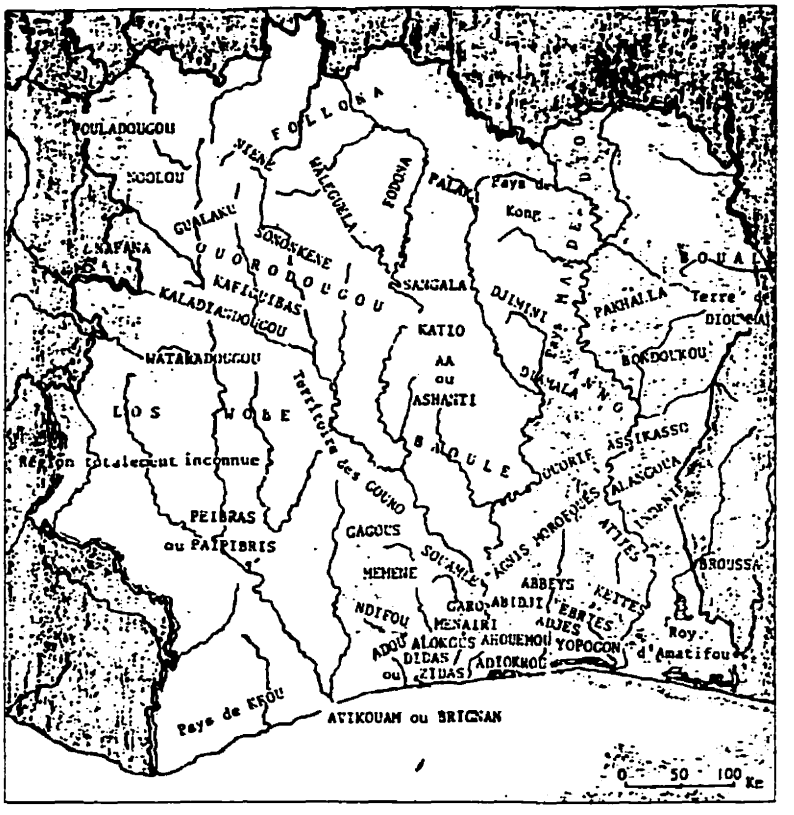

Figure 2.4 • Late nineteenth century "tribal" map. From Dozon and Chauveau 1987.

Angoulvant followed a vigorous policy of "pacification" which relied on less ambiguous tactics such as the bombing and razing of resistant villages, the massacre of able bodied men, and the taking of hostages to win over recalcitrant chiefs. Overall it was "one of the most enduring and most brutally repressed resistance struggles in West African history" (Weiskel 1980:xvii). Transformed into a theatre of combat, the empty space on the map of the interior was brought under French control by 1915 after significant bloodshed (Coquery-Vidrovitch 1992:291-298).

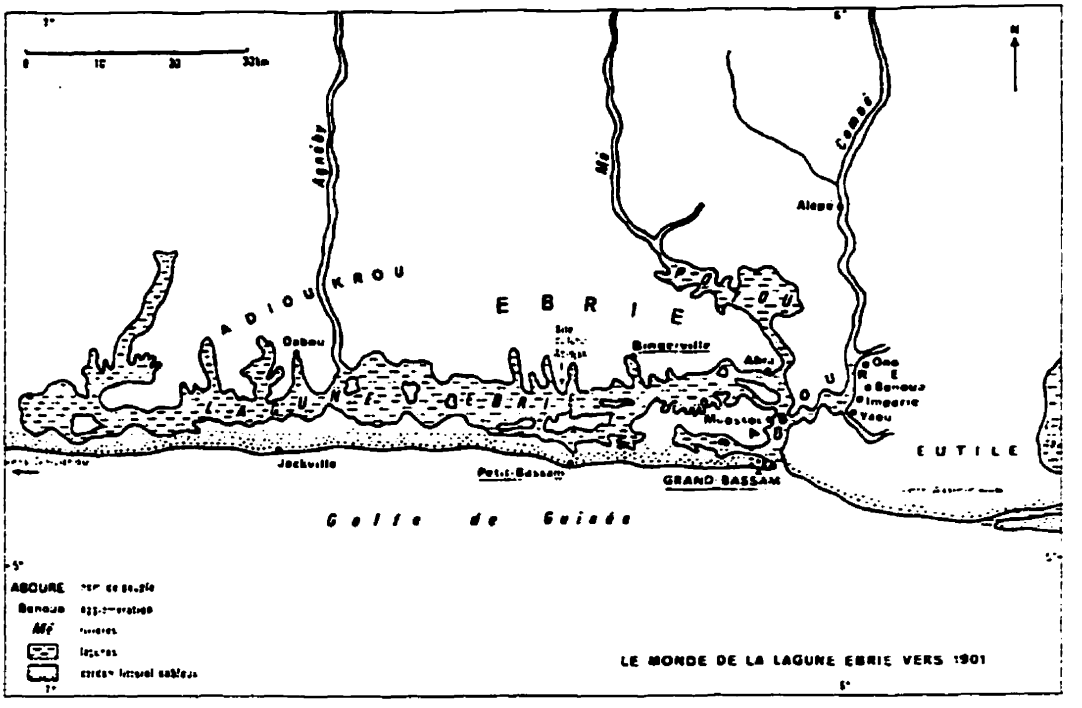

Figure 2.5 • Map of the lagunar coast, showing Grand Bassam, Bingerville and the future site of Abidjan (Wondji 1976).

The new capital, Grand-Bassam, was spared bloodshed; nonetheless, its days as the capital were numbered from the outset. It was a less than an ideal port: the lagoon was too shallow to accommodate larger ships, and strong tides made loading and unloading trading vessels difficult, if not impossible half of the days of the year. To this inconvenience a rather more dramatic problem emerged, as epidemics of yellow fever succeeded each other at the close of the nineteenth century. These epidemics were legion throughout the French *comptoirs* of the West African coast in the nineteenth century, decimating the European populations who lived there. As a result, in 1897 a search was undertaken for alternative sites that would be more salubrious. A number of these were identified, but the colonial administration wavered, reluctant to separate the administrative capital from the commercial centre that was to remain in Bassam because of its bustling port and trading houses. Local authorities were more concerned with the health of settlers, while the Minister for Colonies argued for solutions that would preserve the colony's economic contribution to the metropole (Wondji 1976).

Bassam's yellow fever epidemics occurred in 1899, 1902 and 1903[4], the last one killing nearly all of Bassam's European inhabitants[5]. The later epidemics led to near-panic amongst the settlers, and a mounting rhetoric about epidemic catastrophe produced by colonial administrators finally convinced metropolitan authorities that the administrative capital would have to be moved (Wondji, 1972[6]). A number of sites had been proposed in the 1897 study; the Ébrié village of Adjamé, 25 km further east on the lagoon was finally settled upon in 1899 (see Figure 2.5). Re-named Bingerville after the colony's founder and first Governor, the site was considered particularly clement, as it was situated on a plateau 100m above sea level and swept by breezes. While Bingerville was to become the administrative capital, another site was to become the economic capital of the colony.

Forty km to the east of Bassam, the site of the future Abidjan was draped around the Ébrié lagune on the Gulf of Guinea (see Figure 2.5). Here the land rose steeply inland to form a number of breezy plateaus, and the lagoon broadened and deepened enough to form a natural harbour at a point where the strand of land which separated the lagoon from the sea was at its narrowest. The potential of the site was identified by Houdaille's 1897-99 mission. Houdaille recommended that a canal be constructed across the narrow beachhead and a port established there, which would be linked by rail to the interior. Abidjan was not initially chosen as the new administrative capital ostensibly because the site was not considered as salubrious as Bingerville, which was at a greater elevation and relatively better ventilated. Wondji (1976) has suggested that there was another rationale to splitting the administrative and economic capitals, which, although common in the English colonies, was contrary to the French model of Parisian centralisation. Separating the two would ensure that should one site — most likely the economic

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[4] It was during these years that yellow fever was being eradicated in Havana by Reed and by Cruz in Rio by attacking the *aedes aegyptii* mosquito vector (Cooper and Kiple 1993).

[5] It is likely that, living in an endemic zone, natives would not have been as susceptible because of acquired immunity. The historical literature on yellow fever in the Americas suggest that epidemics broke out either with the influx of large number of susceptible individuals, or when the pathogen was imported to areas that had previously not been exposed to the disease.

[6] Wondji (1972) queries whether the rhetoric corresponded to actual panic amongst the settlers, citing informants who recalled the Europeans' relative calm and noting that a "funereal rhetoric" was *à propos* for the settlers for whom colonial service was imbued with a sense of mission. Dramatic missives of disease, he argues, served to deepen the "apostolic conscience" of settlers. While the point is well taken, the toll the epidemics took suggest that these reports can not be dismissed as a colonial hysteria.

capital, where trade bred promiscuity — be ravaged by an epidemic, the other would be spared.

Figure 2.6 • Houdaille's mission (Diabaté, n.d.)

The "urban" development of Abidjan began in earnest in 1909, in preparation for the railhead which opened with a first section to Bouaké in the interior in 1912 and a second to Bobo-Dioulasso, in Upper Volta, in 1932. Attempts to pierce a canal were unsuccessful. Silt from the excavation accumulated to block the mouth of the canal, a problem that would not be solved until 1950 by Dutch engineers. In the meantime, a wharf was constructed off Abidjan's coast at Port-Bouët. The tides there were as strong as at Bassam however, leading to the same difficulties for loading and unloading ships. Thus, a system of aerial baskets was used (see Figure 2.7). Deprived of a competitive advantage as a port, and in the absence of further epidemics in Bassam, Abidjan did not assert supremacy as the colony's trading post until the mid 30s, when trade through the wharf at Port-Bouët, fed by the railway, would tip the commercial balance in favour of Abidjan. A shift in the colonial centre of power was inevitable, and Abidjan's infrastructure was reinforced by a series of urban developments which commenced in 1920 (Bernus, 1962), spearheading the city's development into a new capital.

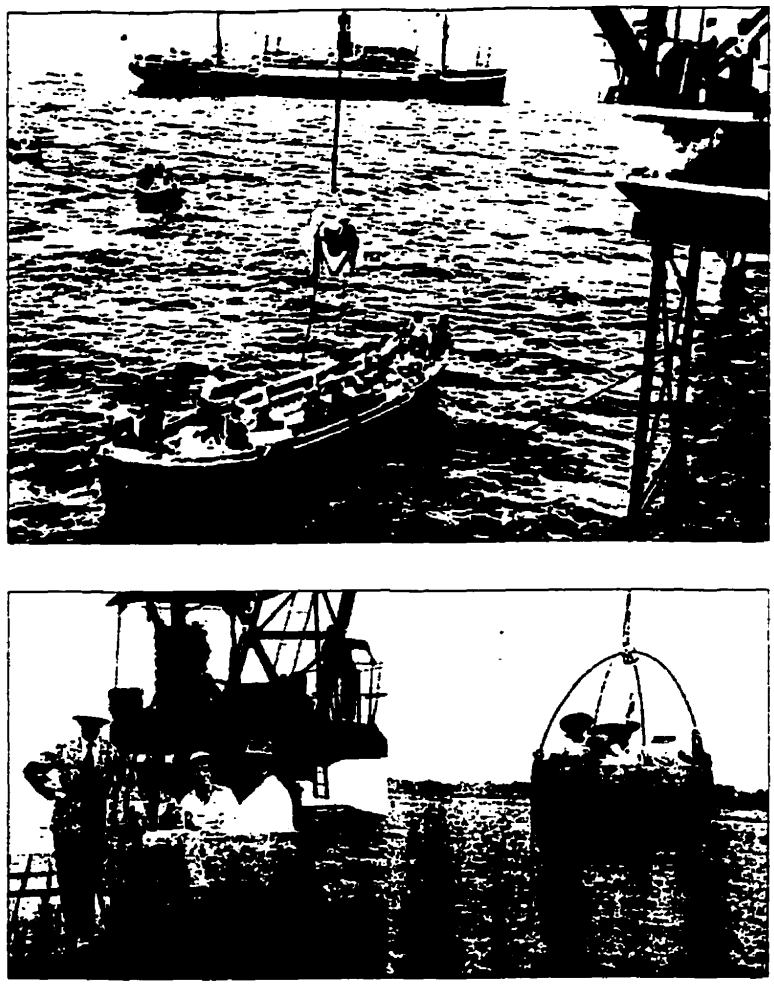

Figure 2.7 • Aerial baskets used to unload passengers at the wharf at Port-Bouët (Diabaté, n.d.).

Abidjan's development into a major urban zone was the result of colonial processes that are still visible to this day. Its location was dictated by colonial health concerns over what were later found to be mosquito-borne diseases. This was a response to the local disease ecology, which had itself been modified by the pathogens that stowed away on trading ships. Thus, the development of the city was a product of both the imperative of territorial conquest and a response to the shifting biologies and disease ecologies of the nascent colony.

From its founding in the early colonial period, the production of space in the city was determined by four interrelated processes. First, the mechanism through which the colonial state distributed the land it had appropriated, and eventually managed its recognition of African land claims: the colonial property régime or

system of land tenure (Haeringer 1969). Colonial land tenure institutionalised territorial domination, and as a result was a key site of struggle between Africans and Europeans. By providing a mechanism for zoning urban space differentially, the colonial property regime led different areas of the city to take different forms.

Behind the apparent neutrality of the property régime lay a second dynamic: the colonial society's representations of the African environment and its natives, particularly in its ideologies of hygiene, and their expression in an array of colonial policies, edicts and practices which instituted a *de facto* segregation of natives from settlers. Settlers' perceptions and representations of Africans obeyed a dynamic of "othering," of perceiving Africans through categories that saw them as the opposite of Europeans. Colonial power assured that these representations were self-realising prophecies, essentially obliging Africans to correspond to settler perceptions.

The third process was related to the economic conditions of empire, which drove migration and contributed to the swelling of the city's African population. Colonial political economy also determined the circumstances under which natives could reproduce their society. In the increasingly monetarised colonial economy, Africans did not own the means of production essential to their survival and had to sell their labour in order to survive.

Fourth, and perhaps most significant, were the array of strategies by which Africans ensured their survival in the city, a plethora of practices that filled in the spaces where the colonial state was unable to regulate the native population. The historical record does not afford much insight into the full range of African practices or the city, being limited to court cases and edicts that arose from their transgressions of French codes. These four processes will now be explored in more detail.

Table 2.1 • Chronology

Early colonial period from the establishment of fortified French trading posts to the establishment of the Colony	1848-1893
Middle colonial period from the establishment of the colony with its capital at Grand Bassam to World War 2	1893-1945 1899-1903 Yellow fever epidemics at Grand-Bassam 1903 establishment of Abidjan 1913 move of capital to Bingerville from Grand-Bassam 1920 Abidjan-Niger railroad opens first branch to Bouaké 1934 move of capital to Abidjan
Late colonial period World War 2 to Independence	1945-1961 1950 Deep water port at Abidjan opens
The First Republic the "Ivoirian miracle" the "crisis" After Houphouët	1961-1999 1961-1980 1980-1994 1994-1999
The Second Republic	2000-

Land tenure: the *régime foncier*

The foundation of the colony under the governership of Binger in 1893 was in effect an annexation of the territory which became the property of France. The French *régime foncier* (colonial property regime) was the juridical framework through which France imposed rule on the territory it had annexed. In response to native resistance, in 1900 the new colonial state acknowledged native claims to lands they had already effectively occupied, that is, the lands which they lived on and farmed. Under this new decree, only vacant land reverted to the state once its vacancy had been ascertained by a 3 month enquête (Manou-Savina 1985).

The movement of the capital to Bingerville from Bassam in 1903 was a watershed because it marked the first significant affirmation of France's territorial imperative in the new colony: until then, the French presence had been limited to its coastal comptoirs whose establishment was negotiated with local rulers to whom France paid tribute (in exchange, the French also negotiated monopoly rights to trade with locals). The site of Bingerville was home to a number of Ébrié villages which had to be displaced for work on the new capital to begin. Establishing Bingerville meant that the Ébrié were invited to relocate their villages from their ancestral sites, as cohabitation with natives was deemed insalubrious at the time, and

epidemics being attributed to "diseased natives."[7] In addition, native labour had to be conscripted to build the new capital. This led to sustained resistance on the part of native Ébrié, eventually overcome in 1904 by a vigorous colonial policy of beatings, imprisonment of village chiefs, bombing, burning and pillaging of villages and the taking of hostages. Ébrié villages were then invited to relocate even further from the new capital, which took on the airs of a fortified camp (Wondji 1976:90-92). The same year Ébrié resistance was overcome the colonial state passed an edict which acknowledged collective land claims of natives by recognising their right to compensation should their land be taken over for urbanisation (Manou-Savina 1985:23).

The colonial state was quickly confronted with another issue: what to do about the native housing that was proliferating in the new city of Abidjan? Not having been fortified subsequent to the kind of violent confrontations with natives that had plagued Bingerville's establishment, and being a trading zone, it was more permeable to natives than Bingerville. Perhaps not wishing to risk further confrontations with the natives, in 1909 the state recognised such spontaneous housing *post facto*, issuing permits but stipulating that the state still owned the land on which these habitations were located. This was essentially a form of freehold. Another concession was granted in 1921, when the right of freeholders to sell their habitations, or to be compensated in the eventuality they were displaced by the state, was recognised. The ongoing significance of such displacements in the lives of African urban dwellers is reflected in the persistence of the term, *déguerpissement*, in the popular vocabulary of Abidjan[8]. In 1943, freeholders saw their right to urban space consolidated by a decree that allowed conversion of the housing permits allowed under the original 1909 decree to "provisional concessions" which could become "definitive" if the habitations were "improved" within two years, effectively granting property rights to squatters who invested in their property by converting temporary structures into buildings made of durable materials. (Ibid).

[7] The hygienist ideology which underlay this segregationist policy is explored below
[8] This can be glossed as "to raise camp".

This administrative legacy of decrees indicate that "spontaneous housing" was a major issue for the colonial municipality. This is not surprising, given the young city's rapid growth during this period:

Table 2.2 • Population of Abidjan, 1904-1955

year	African	Europeans	total
1904	?	6	
1915	1 560	107	1 667
1921	5 207	164	5 371
1929	7 879	1 010	8 889
1934	15 321	1 109	16 430
1939	22 623	1 907	24 530
1955	119 148	8 437	127 585

Le Pape 1985:306

During the pre-war period, the majority of Africans lived in such impromptu housing. In the early years of the city, the European city of the Plateau blended into the indigenous quarter of Cocody on its Eastern fringe (see Figure 2.9). Africans built cheaply, living in "lamentable shacks, huts built of dried mud, bits of crates and old petrol canisters which make of Cocody the most insalubrious agglomeration"[9]. Colonial anxieties about native hygiene, prevalent in the teens and twenties, were heightened by the memory of the epidemics that had ravaged Grand-Bassam and led to the establishment of Abidjan, and were expressed in a series of reports, ordinances and recommendations which enacted an imaginary *cordon sanitaire* around the European quarter by displacing natives away from the Plateau (Le Pape 1985).

[9] From the report of the municipal commission examining the project of relocating the indigenous quarter of Old Cocody, quoted in Le Pape 1985:303; translation mine.

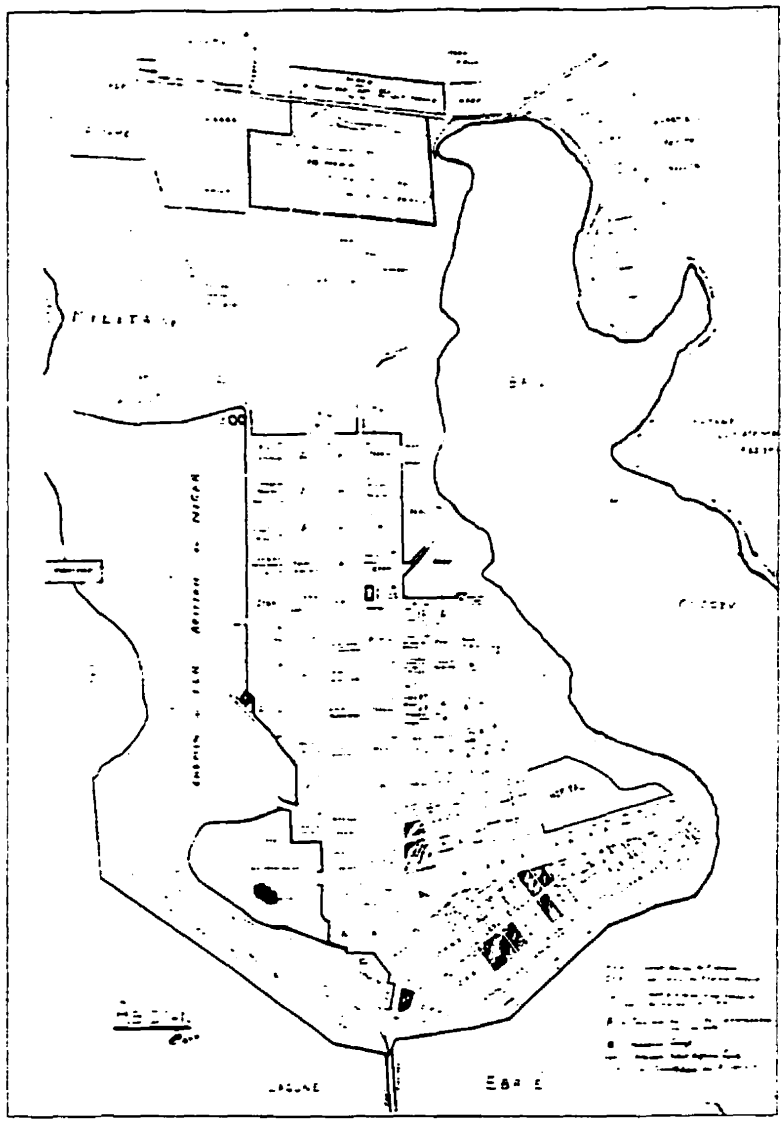

Figure 2.8 • Abidjan 1930s (from Le Pape 1985).

It was with this firmly in mind that Adjamé and New-Cocody to the North and and Anoumabo, an Ébrié village a short ferry ride across the lagoon on the island of Petit-Bassam, were zoned as "indigenous townships". The latter was not officially created until 1923, 10 years after the railway first proposed developing the area to house its workers. By then, the Ébrié were apparently resigned to the realities of colonial urbanisation, no traces of rebellion having been registered in the colonial record. The only controversy occurred between the colonial administration and local European traders, who feared that pushing the development of the African townships outside the commercial zone of the Plateau would hurt business by discouraging consumers and potentially spurring the

development of rival, indigenous businesses in the townships. The new townships were initially little more than Cartesian grids of streets and lots drawn over cleared forest, with no sanitary facilities (Le Pape 1985).

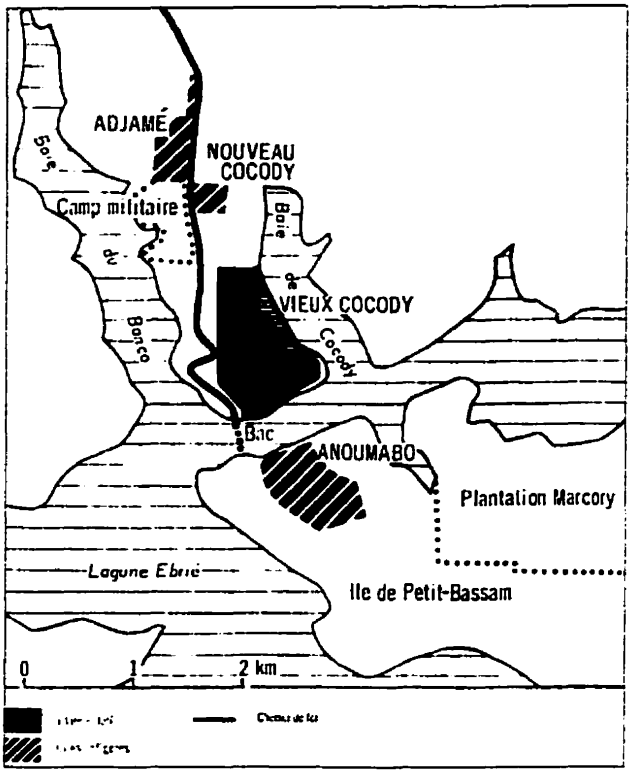

Figure 2.9 • Abidjan 1930s, European and Indigenous quarters (Le Pape 1985).

As a result, by the early thirties, the Plateau would empty of Africans in the evening as day labourers, cooks, clerks and servants, retired to the growing *faubourgs* of Adjamé, New-Cocody and Anoumabo. Despite their location beyond an imagined sanitary perimeter it appears that the improvised quality of the housing in the African townships continued to worry colonial authorities. The 1943 decree which rewarded Africans who "improved" their housing can be seen as a response to the colonial authorities' anxieties about the hygienic and fire threat posed by the intense growth of such spontaneous housing, whose ramshackle condition at times threatened to overwhelm the neat, if slightly cramped, grids originally laid out by the colonial administration in Treichville and Adjamé (Ibid).

Colonial worries about the *bricolé* character of native housing notwithstanding, there was a historical logic to the shape such housing took. The majority of Africans' houses derived from a standard design, that of the housing that was built by colonial authorities to house migrant workers from Upper Volta who were used as labourers in the construction of the new colony. These were called "Mossi caravan camps" as the Voltaic territory had been part of the Mossi Empire. Such camps had been used earlier in the colonial period wherever migrant labour had been requisitioned by colonial authorities. They comprised single story compounds laid out in a series of rooms (*entrer-coucher*, or bedsit) around a common courtyard (*cours commune*) with a single gate onto the street. In the labour camps the common courtyard was managed by a guardian, who collected rent, locked the gate and enforced opening and closing times and other rules (Manou-Savina 1989). However, the *cours* which sprang up "spontaneously" to house the growing influx of labourers were not used as a form of colonial surveillance.

The courtyards were the first site of urban sociality: these were where lodgers met, prepared and cooked food, or just sat chatting. The courtyards gave birth to the first businesses of the city's "informal" economy: watering-holes called, in an allusion to their hiddenness, *maquis*. The *maquis* were largely run by women and persist to this day. They inaugurated a tradition of feminine enterpreneurialism in the city (Vidal 1980). Some of these unregulated *cours* emerged as a concern to colonial authorities because a variety of illicit activities took place there, including the sale and consumption of palm wine. This was frowned upon because of its association with licentious and disruptive behaviour by natives, as evidenced by a series of prosecutions documented in the colonial legal record (Vidal 1989). To this day, the majority of Abidjanais live in housing laid out as *a cours commune*, and the *cours* remain an important space in the everyday life of Abidjanais — a place where social life occurs with all its advantages (a certain conviviality) and disadvantages (lack of privacy). It is widely believed today, by Europeans and Africans alike, not without a trace of romanticism, that the *cours* are a remnant of "traditional" village life in their imagined communality[10]. In fact, as this story

[10] While precolonial villages were organised in familial compounds the resemblance to *cours commune* is a superficial one (Kipré 1988).

shows, the *cours* had their origins more as colonial panopticon than as a traditional community!

Cours communes persisted because they were an inherently rational way of managing space: given the low cost of land relative to construction in the African townships, they were far cheaper to construct than multi-level housing. It would not be until the urban sprawl and "superheating" of the economy, in the late seventies and again in the late nineties, that multilevel housing construction would become economically viable in the former townships. As the city's growth accelerated in the fifties with economic expansion, their exponential construction contributed to the sprawl of the city. The *cours communes* also continued to dominate the housing market because of demand. Rent in the new *cités* (apartment blocks) was too expensive for most Abidjanais, with the exception of bureaucrats with heathy salaries. As the new *cités* were built, alongside would proliferate illicit construction of the *cours communes* type, which had the advantage of flexibility, allowing landlords greater range to adapt to the housing market in the city. They could rent an *entrer-coucher* to single (usually male) migrants to the city, who might be eventually joined by their wives. Larger families could take two or more rooms. In difficult economic times, men might send their families back to the village, shrinking their habitat back to one room and renting out the others. The courtyard was well-adapted to the business of getting by in the urban economy, being able to house the diverse array of the small businesses, more or less illicit, which made up the informal economy of the city. As population density grew, the courtyards could be built into, transforming single rooms into two or even three room apartments.

The colonial property régime was a powerful vehicle for enforcing colonial rule over the use of space, effectively creating a segregated city in its early years. At the same time it demonstrated the limits to its efficacy. The proliferation of attempts to legislate native use of space indicated that Abidjanais commonly transgressed Europeans' implicit rules about the shape the city should take. Ultimately, urban space was both a site of struggle *and* a product of that struggle, growing over the ebb and flow of colonial administration. In this "struggle for the city" (Cooper 1983) we can see the everyday continuation of the colonial war that gave birth to the colony.

Colonial biologies: hygienist ideas and segregation

Colonial perceptions of natives as insalubrious conjugated with older theories of environmental disease causation to legitimate a segregationist ideology. Initially visible in the concerns articulated in the selection of a salubrious site for the new city, these subsequently resulted in Abidjan's division into two zones. One, higher up and healthfully breezy, with European architecture and amenities, was intended for settlers. To this day it is called the Plateau, like other European quarters in many French colonial cities all over the world. Lower down around the dank lagoon, the African townships of New Cocody, Adjamé and Anoumabo (later to become Treichville) proliferated (see Figure 2.9 above). The rationale was simple, and the same that dictated the shape of colonial cities all over Africa: "bad air" was the source of the fevers that regularly afflicted Europeans in the tropics; such miasmas were thought to cling to the native settlements that were clearly insalubrious to the European senses. The miasma theory of disease has, of course, a long history in European biomedical thinking[11]. In Africa, miasma theory and other environmentalist ideas of disease causation persisted even as the discoveries of Pasteur lead to widespread acceptance of the germ theory of the causation of disease in the metropole. That miasma theory remained robust in Africa stemmed from its concordance with Europeans' perceptions of Africans, perceptions that followed an orientalist logic[12].

Much in the way Europeans viewed the Orient as "other" in terms of categories which were the opposite of European virtues, Europeans' African "others" were imagined to be morally impaired, prone to the "lower passions," and intellectually limited. Such views were not confined to metropolitan popular representations, but were part of popular, scientific, and administrative discourse. For example, in 1904, a student sitting the exams for the French Colonial Service received 18 out of 20 points for correctly citing the teaching of French anthropologist Gustave Le Bon: "the young Negro is quite intelligent, but his brain ceases growing at an early age, and thus stops developing" (Cohen 1971:48). Such racist theories comforted Europeans' sense of superiority. European perceptions clearly registered

[11] For a useful, succinct overview see Hannaway 1993.
[12] Of course, the miasma theory was pragmatically effective, in that areas with "bad air" were also those where mosquitoes would tend to breed.

discomfort at African forms of embodiment, particularly when it came to African dances (Tirefort 1999). While references to "handsome peoples," "magnificent specimens" and "virile races" abounded, notions of unhygienic behaviour prevailed, as though to police any residual colonial ambivalences[13]. For Europeans in the nineteenth century, Africa's infamy derived in part from its reputation as "the white man's grave," a metaphor whose origin has been traced to the 17th century experience of the British in Sierra Leone . Confronted with the oppression of the fetid climate, putrid odours and the imagined hypersexuality of the "savages," the miasma theory became a powerful regulatory idea that made sense of the heterogeneous complex of foreign phenomena to which settlers were exposed (Dozon 1991:140). Thus miasmatic theory owed its persistence to its symbolic and practical efficacy in managing colonial experience, even when it was discredited in metropolitan scientific circles with the revelation that mosquitos were the vectors of malaria and yellow fever. The notion that malarial fevers were caused by mosquito born plasmodium parasites continued to justify segregationist policy, as African bodies were believed to be reservoirs for the parasite and a potential hazard to European health. Advances in biomedical science thus substituted the idea of the "diseased native" for that of the "dirty savage"(Packard 1989).

The miasma theory lent pseudo-scientific credence to policies of racial separation. The application of these segregationist ideologies to colonial urban planning was first dubbed the "sanitation syndome" by Swanson (1977)[14]. Curtin (as recently as 1992) has long argued that the syndrome originated with the British experience in India and was subsequently transferred to the new African colonies in the late nineteenth century; Cell (1986) has countered Curtin and states that he overestimates the importance of medical theory relative to the fundamental racism of such notions. Writing independently, Le Pape (1985) makes an argument in the same vein by advocating the term "heterophobia" to refer to how the constellation of colonial ideas about tropical disease, race, African practices and contagion served to legitimate colonial racial segregation. This segregationist ideology is to be distinguished from the ideas of the French hygienist movement of the nineteenth century, which assumed that disease resulted from the

[13] See Bhabha 1995 and Lane 1995 for discussions of "colonial ambivalence."
[14] See also Frenkel and Western 1988 for an example from Sierra Leone.

intertwining of social inequality and poor hygiene, and was split between contagionists who believed in the person-to-person transmission of disease, and anti-contagionists who espoused the miasma theory and saw in the environment the ultimate causal agent of disease. French hygienism did not take hold in the colonies, until much later perhaps because the bulk of pathology in the tropics was febrile, and the hygienists were more concerned with the endemic and non-febrile afflictions of the metropolitan masses (La Berge 1992).

In the French empire, segregationist ideology often found itself at loggerheads with the modern tenets of Pastorianism. This movement followed Pasteur, who was of course the father of the microbe theory of disease, but is also the driving force behind the rise of laboratory science in the making of biomedical knowledge. Pasteur's experiments and rhetoric were convincing enough to influence French state policy, and Pastorian interventions — such as vaccination — were able to demonstrate success once they had mobilised the state resources they needed to be implemented. The French medical corps, up to then in the sway of the French hygienist movement, was not "pasteurised" until the very end of the nineteenth century (Latour 1984). Although the official vector of Pastorianism, the *Société de Pathologie Exotique*, was founded in 1907 the translation of Pastorian ideas into colonial practices took another twenty years. The miasmatic basis of segregationist theory persisted, for instance when edicts written by colonial authorities expressed concerns about hygiene by recommending vigilance over African servants (*boys*) lest they unwittingly provoke disease by reverting to native practices in the settler household. The policing of native settlements that came to settler attention because they were too close, drawing attention to themselves by noise and odour was also recommended (Le Pape 1985).

Pastorian ideas represented a minority, albeit vocal, in the actual government of the colonies. The initial colonial resistance to Pastorianism, with its explicit focus on tropical ("exotic") pathology, seems particularly surprising in the context of the stubborn competition with the British in Africa, where nationalism would have argued for the fervent adoption of Pastorian-tinged hygienism. Other than the usefulness of miasma theory for legitimating segregationist mesures, were there perhaps other reasons for the delayed acceptance of Pastorian ideas in colonial French Africa?

A number of practical barriers to the early diffusion of Pastorianism existed. First, colonial physicians were few and far between, having to cover large territories, obliging them to be frequently absent as they often had to travel long distances to minister to ill settlers. Despite the creation of a Native Health Service (*Assistance médicale indigene*) in 1905, these army physicians were spread too thinly to have much of an impact on native health. When they weren't travelling, their time was largely spent dealing with local administrative problems. These took priority over catching up with new-fangled ideas from the metropole. Second, colonial *laissez-faire* coupled with fear that a too-accurate portrait of health problems would scare off future settlers and investors conspired to keep health records and statistics patchy, and masked the morbidity and mortality due to infectious diseases in the native population. Third, the First World War interrupted whatever institutional continuity existed within the colonial public health service, at a time when the continent was devastated by the great influenza pandemic of 1918 and concurrent epidemics of onchocerciasis, trypansomiasis and leprosy likely triggered by the migratory movements driven by the colonial economy. And finally, the corps of African health assistants were poorly trained, often overwhelmed with adapting to the odd routines of the white man's medicine and thus unlikely to serve as a conduit for new and strange ideas (Bado 1996: 151-190). Thus, cost and the belief that Africans were incapable of learning modern sanitary ways were the main obstacles to implementing a modern public health policy.

The crystallisation of Pastorianism in the form of a network of tropical Pasteur Institutes, French military medical academies, and a reinvigorated colonial public health administration slowly began to overcome these barriers from the 1920s. The tropical Pasteur Institutes were founded in the late nineteenth century throughout the French empire, most notably in Saigon and Nha-Trang (Indochina) and Tunis. The institutes pursued research, applying Pastorian ideas to tropical illnesses. Meanwhile, Pastorian ideas were transmitted through the military medical schools of Bordeaux and Lyon, which trained future colonial medics. The Pastorians' commitment to the vector theory of disease reshaped colonial public health policy from the thirties onwards in the form of campaigns against endemic infectious diseases such as onchocerciasis, sleeping sickness and

leprosy[15]. The campaigns were in response to the devastation wrought by the epidemics of the post World War I period, which decimated the African population throughout the colonies and spurred a metropolitan near-hysteria about the imminent "extinction of the Black race," a worrisome prospect given the colonial economy's reliance on African labour and the hopes it embodied for France's post-war economic recovery. The success of the campaigns fuelled the rise of Pastorianism. An unintended boost to the Pastorians was the establishment of the only medical school for Africans in Dakar, partly to remedy the deficiencies of colonial physicians' African assistants. The school opened in 1918, and in 1920 its mission was described as being to "clean up the country, instruct the Native, give him essential notions of Hygiene, protect him from preventable illnesses, and fortify the race to increase its capacity for work and wealth" (quoted in Bado 1996:217). By then, Pastorian ideas had achieved medical acceptance and institutionalisation: the new native school of medicine assured a wider audience and the diffusion of Pasteur's revolution through a trained class of native intermediaries (Bado 1996).

Latour has argued that Pasteur's germ theory of disease was a diffuse political strategy for giving micro-organisms the power to reshape society[16]. According to this argument, empire was the tool of biomedicine (and not the inverse) and transformed Africa into an enormous laboratory. Empire furnished France and the Pastorians, with a vast laboratory — French Africa — where Pastorian theories could be tinkered and fine-tuned into a truly global science. What was at stake in Empire then was not territorial dominion but the creation of a universal order of knowledge. Thus, the influence of metropolitan ambitions, racist ideologies and economic motives were epiphenomena of a broader historical shift, that from a miasmatic to a germ society[17]. In the young Ivoirian colony, can we say that Pastorian science was a powerful form of colonial politics? In response to the perceived threat of epidemic disease harboured by natives, did Pastorian ideas alter the organisation of colonial society?

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[15] The success of Jamin's 1926 campaign to contain an epidemic of sleeping sickness in Togo, conducted with military discipline and systematicity, played a large part in winning over colonial administrators to Pastorian ideas (Dozon 1985).

[16] Latour, 1984; an earlier version of this argument was actually published later in 1986 (Latour 1986).

[17] See Dozon 1985; 1987; 1991; Marcovich, 1988; Moulin 1992; 1996.

At first, Pastorians' influence remained confined to the realm of colonial public health campaigns aimed at eradicating such tropical diseases as sleeping sickness, leprosy and onchocerciasis. These campaigns took the form of mobile campaigns which scoured the countryside, largely leaving cities untouched (Bado 1996, Dozon 1985). Pastorianism, with its imaginary of a territory criss-crossed by a tactical public health apparatus, was easier to implement in rural areas, where sleeping sickness and leprosy eradication campaigns — complete with forced lymph node sampling and security barrages — were among Africans' most feared experiences of colonialism (see Figure 2.10). In the city, segregationist ideology and the miasmatic theory that underlay it made settlers feel more secure as it prescribed a common-sense practice of keeping natives out and, when they had to be in, turning them as much as possible into Europeans.

Figure 2.10 • Palpating lymph nodes to detect trypanosomiasis. Many villagers fled to avoid such mobile public health campaigns; some even had their cervical lymph nodes removed to avoid the painful injections used to treat sleeping sickness (Domergues 1986).

While segregationist ideologies persisted throughout the colonial period, their hold on urban policy eventually waned as the colonial public health apparatus became increasingly preoccupied with the issue of native health. After the ravages of World War I, France found itself with a demographic deficit: the deaths of so many young men was compounded by a decrease in fertility which followed. As already mentioned, France's African colonies were worse off than France, having been devastated by epidemics of flu, plague, *and* trypanosomiasis. The impact of

these was worsened by the precarious nutritional status of the population, as colonial forced labour practices took men away from subsistence farming. Infertility — the product of declining nutrition and sexually transmitted diseases introduced by Europeans — registered epidemic levels. A decrease in the labour pool available to the colonies would seriously compromise the economic viability of the colonies in which France had considerable stakes. Shifting from the hesitations of the early colonial period and consolidating the somewhat erratic efforts at economic development of the first two decades of the middle period, a doctrine of "maximising the value"[18] of the colonies lent new coherence to colonial policy.

Native labour was needed to produce wealth for France. The Minister of Colonies exhorted his officials in the colonies to adopt policies which would, in a well-known phrase, "*faire du nègre*" ("breed Niggers"). The phrase was delicately translated by colonial ideologues to "developing the quantity and quality of the indigenous races,"[19] implying an investment in human capital. The emerging pro-natalism of the colonial state ("quantity") was thus connected with an embryonic concern with worker health ("quality"). As a result, colonial authorities were successfully lobbied in the early twenties to undertake measures to "save the Black race." In French West Africa (known by the French acronym for *Afrique occidentale française*, AOF), the number of physicians increased, from around 30 at the outbreak of World War 1 to 92 in 1925 and 133 in 1926. The health budget went from 10.3 million francs in 1925 to 18.6 then 25.7 million francs in 1926 and 1927 respectively; every colony was instructed to devote between 7 and 12% of its budget to health (Bado 1996:228). Timid investments were made in the creation of a public health system articulated around central hospitals with diagnostic facilities, peripheral dispensaries that would assist hospitals in ascertaining and monitoring the diseases that afflicted the population, and mobile campaigns to stamp out preventable diseases. These early investments disproportionately favoured cities and towns, establishing a pattern that was reinforced when more substantial investments were made after World War II and that remains to this day.

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[18] Albert Sarraut is credited for the doctrine with his book *La mise en valeur des colonies françaises* which was published in 1923.
[19] Sarraut, quoted in Bado 1996:227.

Thus the hold of segregationist ideologies over the urban imagination relaxed as a result of a shift in metropolitan perceptions and desires for the colonies. Once native health emerged as a positive concern, the institutional network and ideological stake in the tropical "turf" gave Pastorianian ideas a tactical advantage over the French hygienists. As "indigenous" health became the focus of bio-medical intervention, segregation was no longer a relevant policy. However, by then the city's two-tiered structure was firmly anchored in its morphology and its economic structure, making any explicitly segregationist ideology superfluous to maintaining the status quo. It would not be until Independence and the high-modernist moment of the postcolonial state that race would fade as the determinant of the city's form, to be replaced by class. As a result, Pastorianism never had an impact on the city's form. Nonetheless, whether the vehicle was Pastorianism or segregationist ideologies, the biology of the tropics — the "long conversation" between European and then African bodies and the disease ecologies that themselves were a product of urbanisation, trade, and migration — shaped both colonial discourse and the material configuration of the city.

Whether the separation between Europeans and Africans resulted from explicit or implicit (to the extent that it was medicalised) racist policy did not matter from a practical point of view. Land on the Plateau was zoned first and, this area being equipped with a European infrastructure (roads sewers and so on) the cost of land and rents was much higher, forming an economic barrier to Africans' living there. This rendered any overt policy of segregation unnecessary. The African townships had only rudimentary facilities, and the natives were crowded into dark and cramped quarters. In those conditions, hygiene deteriorated and, not surprisingly, health suffered, fulfilling the prophecy of the diseased urban African and confirming settlers' faith in the validity of miasma theory and segregationist practices.

Political economy and colonial mobility

Abidjan's population growth, shown in Table 2.1 above, was fuelled by the in-migration of Africans resulting from the advent of a capitalist economy and the necessity that Africans sell their labour in order to pay head taxes. Migration transformed the city, mainly through the growth of "spontaneous" housing which

sprouted up to house the migrants, pushing colonial authorities to attempt to legislate order back into the expansion of the city. As we have seen, migration was the result of metropolitan policy aimed at developing the colony, but grew to generate its own dynamic of colonial mobility. The most significant migratory system, not only in Abidjan but in the region, persists to this day: currently, an estimated third of nationals of the former colony of Upper Volta (now called Burkina Faso) reside in Côte d'Ivoire (Cordell, Piché and Gregory 1996).

The majority of initial migrants to Abidjan were labourers, brought in to build the infrastructure of the new capital, and as mentioned above, most of them came from the French territory of Upper Volta, at the terminus of the RAN (*Régie Abidjan Niger*) railway. This colony was centred on the Mossi Empire, which had been conquered by the French in the late nineteenth century. At the time, the French were struck by the population density of the Mossi towns and cities, which to them seemed incongruous with the Sahel's aridity, at least in comparison to the rich forests to the south. The French explorer Crozat declared, on his visit to the Mossi country in 1890, that the population there "is surprisingly dense for a Black country. There is here an enormous capital, immediately exploitable"[20]. This observation gave birth to a colonial policy of using the Voltaic possession as a human reservoir for the labour needs of the new Ivoirian colony. So was born the "push and pull" migration system which links Burkina Faso of today with its wealthier neighbour to the south.

[20] Quoted in Skinner 1965:62.

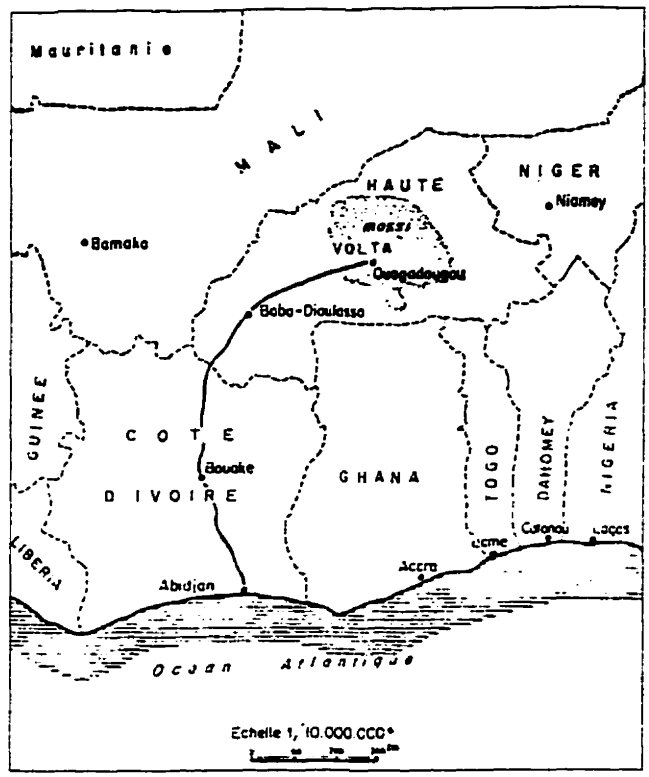

Figure 2.11 • The Régie Abidjan-Niger Railway.

The French had realised early on the agricultural potential of the "Basse-Côte", as the forest and coastal zones of Côte-d'Ivoire were known. In addition to the plentiful fruits and indigenous cultivation of palm oil and rubber that they had already been trading since the nineteenth century, the French saw a vast potential in the area for producing coffee and cocoa. The establishment of a plantation economy intensified with the French cross-colonial doctrine of *mise en valeur*, which advocated aggressive infrastructural investment and social engineering of labour markets to bring to fruition the full economic potential of the colonies by manning the plantations and construction sites of the new colony's infrastructure. By the thirties the seeds the French had sown for the development of a plantation economy had begun to sprout, as natives shifted into plantation agriculture of coffee and cocoa. Paradoxically, the plantation economy developed a momentum of its own, at times overlapping and at times contradicting French policy in various areas of the country. Ultimately, the plantation economy largely developed autonomously of French colonial policy as natives emigrated to the British Gold Coast where wages were better, or started their own plantations and became more productive than French planters because they were more efficient at

recruiting and retaining native labour (Chauveau and Dozon 1985). These labour markets constituted the "pull" of the migration system.

The "push" was furnished by colonial labour policies for mobilising labour. Slavery was abolished by the French in their possessions in 1848; however, the French moved slowly to enforce abolition out of fear of estranging slave-owning local allies. Abolition was useful to the French in that it created a labour reservoir of freed slaves (Cordell, Gregory and Piché 1996:61). Simultaneous with abolition, forced labour was instituted by the French, initially using a crude system whereby every village was obliged to furnish a certain number of man-days of labour. While initially this was intended as a civic works measure to enhance local infrastructures, it quickly became a mechanism for mobilising labour at no cost. Some French colonial administrators took blatant advantage of the free labour, using it to build extravagant monuments to themselves (Skinner 1965). Conscription also served colonial labour needs. Mobile draft boards registered men, administering physical examinations to determine their suitability for service. As the number of men who were consider "apt for service" (that is, had passed their physicals) exceeded military needs, colonial authorities quickly pressed this "second portion" into service on various colonial development schemes (Echenberg 1991).

Migration to Côte-d'Ivoire, largely from the "labour reservoir" of the Upper Volta was also driven by head taxes levied on villages. Head taxes increased throughout the years of the French presence in Upper Volta, which had been administered by the French since 1896 and became a colony in 1919. As a result, Voltaics were obliged to sell their labour, reluctantly moving south to the Ivoirian colony to enter the "voluntary" labour system[21]. Wages were poor and working conditions difficult. Mortality on the construction of the Abidjan-Niger railroad was so high that "white man's work" earned a reputation for "eating people," an expression interpreted by the French anthropologist Labouret in 1938 as evidence of a belief in mythical cannibals (Skinner 1965:65). Conscription into the army, forced and contract labour served to drive migration of Northerners, largely Voltaics, to Côte-d'Ivoire and to the Gold Coast, where pay and economic opportunities were

[21] During these years, more Voltaics actually migrated to British Gold Coast, where wages were higher. French colonial authorities responded by sweetening the conditions of "voluntary" labour and cutting back on "forced labour" which was mainly used locally.

better. These labour measures competed with each other, sapping Upper Volta of practically all its able bodied men and in turn fuelling the demographic crisis that so worried metropolitan authorities. The incoherence of colonial policy was illustrated by the failure of the French to initiate cotton production in Upper Volta. Natives refused to plant, as it was more profitable to migrate and sell one's labour on the plantations to the South than to stay around to harvest the cotton in December, long after the staple, millet, had been harvested in late October (Skinner 1965:70).

Partly because of such irrational management, but largely because of the impact of the Great Depression which was felt 1929, the colony of Upper Volta was declared insolvent in 1931. As French colonies had to be self-financing, the Voltaic colonial administration attempted to compensate for the shortfall in export revenues by raising head taxes during the Great Depression. The strategy was a disaster, impoverishing the native population to the point of famine, and the French administration dissolved the colony, and folded it into Côte-d'Ivoire. Ivoirian planters had lobbied for integration of the Voltaic colony in order to have easier access to Mossi labour, effectively using the colonial state to institutionalise the migratory system between Upper Volta and Côte-d'Ivoire (Skinner 1965: 64).

While the majority of immigrants to Côte-d'Ivoire from Upper Volta did not go to Abidjan, they made up the bulk of those who settled in the city. Other groups were similarly imported by colonial policy: while the Mossi were brought to Côte-d'Ivoire as labourers on the railway or in plantations, others were moved for other functions. The French relied on colonial ethnographic observations to bring in people of different ethnicities to occupy positions deemed appropriate to their backgrounds. Dahomeyans and Senegalese, having had access to French colonial education, became clerks in the colonial administration; northern traders, speaking the lingua franca of Dioula, were brought in to ensure commerce; hardy Baoulé joined "Mossi"[22] to labour on the plantations (Challenor 1979, Dozon 1997). The coercive constraints to labour migration were gradually lifted after World War II, but by then migration had become a way of life for the Mossi and, indeed, throughout the region. The story of Mossi labour migration is one

[22] Voltaics were often referred to, or referred to themselves, as Mossi as this was the dominant ethnic group in the colony; the conflation of ethnicity with geographic origin was a product of colonial administration (see Chapter 3).

example among many of how native groups, marshalled under their ethnic labels, were rounded up by the colonial state and pressed into the service of a capitalist economy[23].

All these colonial mobilities, whether the Upper-Volta-Côte-d'Ivoire seasonal migration system or smaller networks of traders, clerks, and agricultural workers, were distributed across the entire colony but increasingly focused on Abidjan, the terminus of the railway and the new economic and administrative capital. As we have seen, the push for migration was provided by colonial labour policies; the pull was furnished by the labour markets of the plantations and construction sites of the new colony. Mobility was accelerated by the infrastructure that was the key to French development of the colonies, the roads and the Abidjan-Niger Railway. French authorities encouraged mobility by abolishing administrative barriers to workers' travel, building railway hostels and offering special fares for native workers travelling in groups of ten or more. This infrastructure channelled mobility in new ways, swelling villages and towns along the growing arteries of commerce and leaving behind others that were not connected. Many villages were relocated onto the new colonial arteries (Zan 1976). Mobility transformed culture and society at its point of origin and destination. At origin, in Mossi villages, migration transformed everyday life, modes of production, material culture, political systems and even kinship as it gave young men economic power, loosening the hold of traditional systems of marriage (Deniel 1968). At destination, Mossi women were sought after as wives by men from matrilineal clans, as marriage to them would not mean loss of one's capital to one's wife's family (Skinner 1965:71-75). Mobility became a way of life, as migrants who had built up networks at both origin and destination took advantage of the fall in the transaction costs of trade afforded by the colonial transportation infrastructure.

In summary, then, migration to Côte-d'Ivoire in general and Abidjan in particular was a self-perpetuating system organised around three elements: the "push" of forced labour, conscription and head taxation that monetarised the economy. These factors defined the points of origin for migration. "Pull" was furnished by the requirement for unskilled labour for the development of a colonial

[23] Chauveau and Dozon (1985) have explored the production of ethnicity through the plantation economy; see chapter 3.

infrastructure that drove migration in the early colonial period, and would remain an important determinant of migration in the building boom of the early post-colonial drive to modernisation. Development of the plantation economy became the most significant driving force starting in the twenties until the advent of the economic crisis of the late seventies. The generic pull of the booming economy of the Ivoirian "miracle" of the sixties and seventies along with the continuing "bright lights" of the francophone metropolis[24], the largest in French Africa, clearly plays a significant role to this day. And finally, migration was an avenue for social change, reconfiguring social relations and opening up economic possibilities for Africans. This will be further explored in the next chapter.

Colonial political economy was the reflection of a welter of metropolitan development ambitions and local colonial agendas that, on the ground and in the field, often worked at cross-purposes. The net effect was to institute a logic of migration, the most compelling manifestation of which is the extensive migratory system which to this day ties Burkina Faso and Côte-d'Ivoire. As will be discussed in chapter 3, migration crystallised ethnicity even as it transformed kinship relations, reproductive and economic strategies at both ends of the migration cycle. Infrastructural developments, facilitating the displacement of people and goods, accelerated migration to the point where one can speak of a new colonial mobility that was associated with the integration of the population into a monetarised economy and the global capitalist economy.

Conclusion

Colonialism, in Côte-d'Ivoire as elsewhere, marked the entry into a capitalist global economy. Colonial cities were nodal points, "theatres of capitalist accumulation" but also contact zones that registered accelerations in transformations of social relations. These have been largely viewed through the prism of modernisation theory, which has seen the colonial city as the place where "detribalisation" and its inverse, "modernisation" occur, whether on the register of the political ("urban headmen"), the cultural ("urban kinsmen") or the

[24] In addition to the lure of the big city, it should be noted that many come to Abidjan to either work in skilled jobs in its diversified economy or to study; it has, for instance, one of the top-ranked medical schools on the continent.

psychopathological ("adaptation syndromes"). In this view, modernisation produces urban society. The colonial history of Abidjan highlights the origin of colonial cities in wars of territorial conquest, and how the production of urban space is concurrent with the mapping and subduing of its hinterland: in short, it is a process of territorialisation. Colonial land tenure and native strategies for constructing a habitat under colonial rule were the continuation of that struggle, manifested as a register of ordinances and ideas about health. Settler resistance to Pastorian ideas, with its commitment to a universal biology and antimicrobial methods to control disease, demonstrates that racist ideas were particularly robust, sustained by the powerful experience of alterity, of "otherness," that tended to overcome settlers in the dank tropics. Underlying this experience were the biological changes resulting from trade, migration and urbanisation. Malaria and yellow fever were, for Europeans, the most dramatic examples of the diseases of warm climates that always threatened to turn the colonial adventure into a "white man's grave." Biology changed for Africans, as with colonialism the "*grandes endémies*" (onchocerciases, trypanosomiasis, and leprosy) combined with the "urban" diseases common in Europe (tuberculosis, syphilis and gonorrhoea) to fulfil settler images of natives as "diseased."

The hallmark of African colonial modernity was *mobility*. Mobility was the obligatory response to colonial rule, whether to avoid forced work, colonial public health campaigns, conscription or to sell labour in order to pay head taxes. Mobility spiralled, as transportation infrastructure turned movement into a way of life and reconfigured space around a grid of roads and railways. As people moved, the notion of ethnicity became increasingly important. Ethnicity became a fundamental part of the colonial state's practices of naming and controlling populations, but urban experience also heightened the salience of ethnicity for natives who, like their colonisers, confronted with alterity. As a result, colonial mobility *produced* ethnicity as a widespread, crosscutting form of self-consciousness institutionalised in various forms, whether it be "modern" State practices of naming ethnic groups (through mapping) and individuals (through censuses), or "traditional" practices of everyday life (see chapter 3). Settlers and natives co-produced the space of the city. As we shall see in the following chapter, in the process both were tangled in a colonial modernity that erased the native even as it produced her.

Chapter 3
The culture of colonialism

Introduction

The previous chapter examined how the predicaments of colonial domination were materialised in the processes of urbanisation, mobility, and in the government of the indigenous populations, all indices of transformation in social relations. Colonial domination produced social change through these material practices. Before turning to the postcolonial period, this chapter will examine the strategies through which Africans engaged with colonial modernity. It argues that culture — the collective representations through which people view the world they live in and inform their behaviour, as well as the practices that structure the flow of everyday life — was shaped by these material processes.[1] Culture served to mediate the social changes wrought by colonialism.

This chapter is concerned with exploring some of the mechanisms through which Ivoirians engaged with colonialism. Voluntary associations, religious movements and appropriations of ethnicity are examples of how individuals imagined their relationship to the world they inhabited and the realities of material existence, including the colonial state itself. These forms of collective action that never had as their goal the acquisition of state power, nevertheless contributed to forming a public sphere that would form the basis for a nationalist politics leading up to

[1] The notion that collective representations shape social life has a long genealogy, from Durkheim (religious life; see also Lukes 1973) to Althusser's notion of ideology (1996) which marked both the "articulation of modes of production school" and British cultural studies. These approaches differ in their understanding of the origins of these representations, they can be glossed as seeing in them a social cement used to overcome anomie or disguise conflict.

Independence in 1961. They tell the historical story of how individuals actively constituted themselves as citizens and as subjects of the nation, and show how culture — ethnicity, sociability, collective consciousness of a new modern age — was a strategy for mediating the social changes of colonialism. Culture, as a mediating strategy rather than as "tradition," would continue as a strategy for mediating social change in the postcolonial period. In the context of Ivoirian urban modernity, it mediated the global shifts in capitalist production and exchange that started in the 1970s. This resulted in a particular bio-social substrate that crystallised the AIDS epidemic of the 1980s and beyond.

Côte-d'Ivoire's colonial period was marked by distinct social processes that continue to play a role in contemporary Ivoirian society. Together, these processes set the conditions by which modern social forms that are nowadays taken for granted — ethnicity, the individual, national politics, civil society — could emerge. Three distinct processes can be identified. The first comprises how colonial constructions of ethnicity were the result of State practices that mapped and governed the territory by ethnic region, and in the way in which natives appropriated these constructions to make a place for themselves in a new social reality. Over time, these constructions hardened to become major rhetorical tropes, with significant political consequences in the contemporary life of the nation. In this sense, "culture" emerged as a pivotal strategy for mediating colonialism and, in the postcolonial period, politics[2]. The social movements that followed in the wake of the Prophet William Wade Harris were a second process. The European religious idiom of Christianity served to articulate a broad consciousness of modernity and social change. And the third refers to how voluntary associations of various kinds (youth groups, church clubs, sporting associations and the like) worked to metabolise social change. They helped to dissolve previous ways of life by serving as channels for new social forms and as laboratories for experimenting with novel social relations. These processes are still visible today in the voluntary associations that have responded to the HIVAIDS epidemic (see Chapters 8 and 9). Though heterogeneous, these phenomena — the strategies for creating and appropriating ethnic identification,

[2] Succinctly put, ethnic categories have re-emerged as polarising rhetorical figures in the public sphere, particularly in the years following the death of President Houphouët-Boigny in 1993 leading up to the fall of the First Republic in 1999 and since, with the ethnically-tinged massacres that marred the birth of the Second Republic in late 2000.

voluntary associations and religious movements — nonetheless represent a social space within which Ivoirians engaged with the social changes wrought by colonialism. However, in this discussion of colonial social change, it must be kept in mind that these processes were inscribed within — or arguably the sublimation of — a broader dynamic of colonial domination.

The territorialisation of French rule, the ensuing production of space and its integration into a global capitalist economy discussed in the previous chapter are examples of the "arterial" nature of colonial power[3]. This was a form of domination at its systolic phase, characterised by the use of military force and the enforced transformation of how people and societies ensured the conditions of their own reproduction. Colonial rule was consolidated once the territory was secured in 1915. Although arterial forms of domination ebbed to some extent thereafter, traces lived on. The *indigénat,* for example, persisted until 1946. The *indigénat* juridically empowered Europeans to punish Africans on-the-spot for misbehaviour. It was, of course, much despised, and the most vivid reminder of domination in the everyday lives of Africans throughout French Africa.

However colonial power also had a "capillary" aspect (Foucault 1987). Thus, colonial power not only comprised active forms of constraint and punishment, but also seeped into the ways in which natives constituted themselves as subjects of colonial rule. In the interstices of colonial domination, strategies other than fight or flight were possible. It is here that we can find the traces of native appropriation of the transformations to which they were subjected. These tactical moves on the part of Africans occurred within the framework supplied by colonial domination in general and the colonial state in particular. These were lateral manifestations of Africans' response to the colonial situation, neither overt resistance nor mute acquiescence to colonial authority. Rather, they are best understood as a historically located pragmatics. As remarked in the previous chapter, traces of native agency were elusive. The colonial record of housing ordinances, migration and escape from regulations only intermittently allows the voices of natives to be heard, most notably in court records, but it does allow us to recover native agency through spatial practices. As we have seen in the previous chapter, outright revolt and resistance gave way to native appropriations

[3] The term is from Cooper 1994.

of urban space and of mobility. *Cours communes* were turned into *maquis* (informal bars); railroad journeys were used to trade onions and chickens up and down the line and the proceeds to finance other trading trips.

Although not part of any broad strategy aimed at undermining the coloniser, the cumulative effect of these tactical manifestations was two-fold. First, they set the stage for the emergence of a nationalist politics by opening up a space of public debate and reflection on colonial rule. And second, they put in place the machinery by which natives actively constituted themselves as colonial subjects. This machinery operated on two levels: through the ethnic categories the colonial state had ascribed to natives and that conditioned their relations with it, and through the plantation economy that, once in place, was harnessed by natives to achieve a limited economic autonomy.

Cartographic reason and the ethnographic state

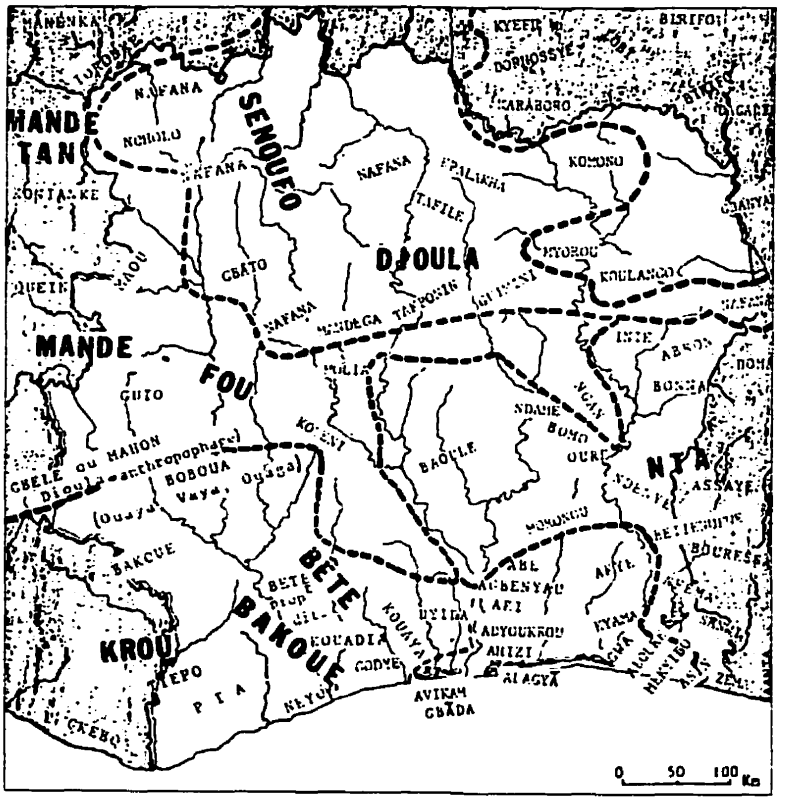

Figure 3.1 • Ethnographic map of Côte d'Ivoire 1913. From Chauveau and Dozon, 1987.

Colonisation, the military domination of a territory, was inextricably bound to practices of mapping. Once the territory was secured, the exploratory missions discussed in the previous chapter were consolidated into a systematic program that linked mapping of the territory and naming the populations that inhabited it. The colonial state, as a result, conjugated a cartographic project with an ethnographic one (Chauveau and Dozon 1987). Mapping is both an instrument of rule, construed as a rationalised relationship between the state and its territory, and, as will be shown, a practice that constituted that rule (Biggs 1999). The project was a belaboured one: the colonial presence required vigorous military support, colonial administrators were few and far between, did not speak local languages and, in the beginning, had few local people they could rely on to help them carry out their administrative duties (Cohen 1971).

The task of mapping the colony and its inhabitants built on the work of the French ethnographer-explorer Maurice Delafosse, whose 1904 work *Vocabulaires comparatifs de plus de soixante langues ou dialectes parlés à la Côte-d'Ivoire et dans les régions limitrophes* formed the basis for a "genealogy of races" of the territory. This ethnic inventory of the colony, while viewed as provisory and incomplete even by its author, congealed quickly and changed little thereafter. The colonial state did not require further detail to govern, and contented itself with grouping tribes into "families" such as the Kru or the Akan. Naming was part and parcel of the "cartographic reason" of the state, which used tribal families to divide the territory into large swaths — the "Senoufo country" or "Baoulé country" — made up of smaller tribal zones (see Figure 3.1). Solidification of ethnic categories was not just a product of mechanical ascription by the state: by the 1920s natives were appropriating these labels in order to deal with colonial authorities.

Implementing metropolitan policies aimed at economic development in the 1930s, the colonial state began to invest heavily in the development of a plantation economy. Correspondingly, it shifted from a "cartographic" approach to the natives to an ethnographic one, differentiating ethnicities according to imagined aptitudes and predispositions. Terms such as "quarrelsome," "unstable," or "admirable" were used to classify groups in order to better manage their role in the colonial economy. This labelling was a self-fulfilling prophecy characterised by "working misunderstandings," processes of misrecognition which nonetheless

established the framework which would govern relations between natives, the state, and the colonial economy.[4]

The Baoulé are an interesting case study of how colonial practices of enumeration and naming both hardened ethnicity and served to delineate the stage on which the politics of nation-building could occur. In the most recent census of 1988, the Baoulé are the largest ethnic group in Abidjan and Côte-d'Ivoire; not insignificantly, President and founder of the First Republic (see chapter 4) Houphouët-Boigny was Baoulé, as is his successor, Henri Konan Bédié (although not *his* successor, General Guei, who overthrew him in the Christmas Eve 1999 coup). Although one cannot speak of a *baoulisation* of the state the way one can of *wolofication* or *mossification* in Sénégal and Burkina Faso respectively, the Baoulé are considered the politically dominant ethnicity in this most multicultural nation. The demographic history of the Baoulé contains a puzzle: the depression of the 1930s, like the demographic crisis immediately after World War 1, shrank the population of the colony as nutritional inputs decreased. Yet from 1936 to 1948, according to census information and colonial records, when the rest of the colony was just barely recovering from the demographic effects of the crisis and starting to stabilise population loss, Baoulé grew at an astonishing rate of 4.8% per year, far above what was considered "natural" (around 2%). Baoulé demography actually shrank by 4.4% from 1948-1950, then spurted again at an astonishing 8.5% while the colony's aggregate population was growing at 4.6% (Chauveau 1987). How did this happen?

Two hypotheses have been advanced to explain this. A political explanation proposes a process whereby demographic dominance leads to political dominance, which in turn leads to individuals 'converting' to the politically dominant ethnicity, swelling its demographic ranks. In contrast to this 'snowball' hypothesis, culturalist explanations have looked to marriage patterns and kinship structures to explain demographic increases. The Baoulé are matrilineal and weakly polygamous. Exogamy was widely accepted, and offspring were recognised as Baoulé. The low rate of endogenous polygamy (that is, marriage

[4] This argument is made in great detail in Chauveau and Dozon 1987 drawing on material published by the same authors in 1985. Reference to the self-justifying labelling of natives and the particularly apt term "working misunderstanding" is drawn from Dorward's 1974 discussion of a similar process in relations between the British and the Tiv of Northwestern Nigeria.

amongst Baoulé), it was argued, freed up Baoulé women for exogamy. However neither explanation is historically robust. Baoulé were never demographically dominant *anywhere* outside their own region until 1955, when they became the dominant ethnic group in Abidjan. Political dominance did not occur until Houphouët solidified his hold over the State and the Party, after independence in 1961 — and *after* both demographic spurts. Finally, the Baoulé were not the only matrilineal society in Ivoirian space — in fact, all the Akan group including the lagunar peoples (demographically dominant, of course, along the coast) were also matrilineal. Political and cultural factors may have played a part, but cannot fully explain the phenomenon.

Figure 3.2 • Syncretic Tomb. From Berron 1980.

The answer lies in a practice of the colonial state. Ethnographers and historians have observed that the Baoulé never "crystallised" a social structure. According to early informants, the term "baoulé" actually refers to a form of sacrifice performed by a group of dissidents as they left what is now Ghana in the mid eighteenth century in a dispute over the succession to the Ashanti throne. Some of them settled in the central region of the colony, in an area that was a hub for commerce, and integrated with other local groups. They became an "interstitial" ethnicity whose lack of strong political and social organisation allowed them to mesh with other groups (Chauveau 1987). Given the heterogeneity of Baoulé social structure, it is unlikely that they ever were a "tribe" in the sense of classical anthropology. Rather, the Baoulé were a diverse group of people some of whom

shared the same myth of origin but, mainly, who had migrated to the same geographical area.

When the French conquered central Côte-d'Ivoire, they designated all inhabitants of this area as "Baoulé," conflating toponymy with ethnonymy. Here, the cartographic state relied on partial ethnographic theories to label the entire region, and whomever happened to live there, as Baoulé. In this sense, the Baoulé were a residual category, whose ranks were swelled through colonial ascription of this ethnic name to other inhabitants of a region that was already a crossroads, and for whose inhabitants mobility was a way of life. In other words, mobile social groups without strong sociocultural institutions were more likely to be labelled Baoulé by the colonial state. Coupled with the tendency for exogamy shared amongst those the state labelled Baoulé, mobility facilitated the diffusion of Baoulé identity. It was this process that colonial censuses registered as prodigious demographic growth. Not surprisingly, the periods of strong Baoulé demographic growth (1936 to 1948 and 1955 to 1965) coincided with when urbanisation — and therefore mobility and outmarriage of young "Baoulé" women — was at its peak[5]

The French distrusted those they called the Baoulé who had been amongst those who had most fiercely resisted colonisation (Weiskel 1980). As a result, the Baoulé were never assimilated into the colonial economy as a professional category, in the manner of the Dioula (as traders), the Dahomeyans (as clerks), or the Agnis (as planters). Baoulé initially entered the colonial plantation economy as labourers on plantations in the 'Agni country' in southeast Côte-d'Ivoire where colonial authorities first introduced coffee and cocoa plantations. Gradually, with accumulated savings, they purchased land from Agni and began planting for themselves. The looseness of Baoulé kinship was an asset, as planters were able to exert claims over a broader range of young male kin across lineages compared to other groups where such claims were more tightly restricted by kinship (Hecht 1984).

Thus mobility reconfigured the ethnic map of the colony. These shifts had effects which played out in multiple historical registers. Perhaps most significantly, they

[5] For a full account, see Chauveau 1985. Weiskel 1980 gives the most detailed precolonial history of the Baoulé but takes the ethnicity at face value. A similar argument for the colonial constitution of an Ivoirian ethnic group is Dozon 1985.

solidified ethnic categories. Ethnic labels were used to distinguish in-migrants (*allochtones*) from "true" natives (*autochtones*). This promoted the ethnicisation of the economy, as specific groups followed the paths of economic differentiation they had been placed on by French colonial policy. Groups such as the Baoulé — perhaps because of their historical experience of migration and assimilation — quickly learned the planting trade, accumulated capital and used it to purchase land in order to become themselves planters. This led to the emergence of a native planter class, understood by some commentators as a proto-bourgeoisie (Amin 1967), which came to dominate politics after World War II through the personality of the new independent Republic's first President, Félix Houphouët-Boigny.

Demographic and historical accounts have pointed to the intensification and acceleration of mobility under colonialism. Colonial mobility certainly contributed to fashioning ethnicity as a social fact, as Africans moved in greater numbers farther afield and were therefore confronted with a multiplicity of "others": Africans who came from other regions and had different traditions. Ethnicity, in this situation, is a shortcut to managing difference. In the way one might appeal to "custom" to explain particular habits, tradition is reinvented and re-presented (Ranger 1983). Ethnicity, as a reflexive appropriation of tradition in the management of identity, was produced through the practices of colonial cartography and administrative ethnography (Amselle 1998, Wooten 1993). At the heart of ethnicity, then, lay the colonial state (Chauveau and Dozon 1987).

Modernity's prophets

As elsewhere in Africa, Côte-d'Ivoire's colonial, and postcolonial history was punctuated by prophetic movements and millenarian cults. What appears to be unusual in Côte-d'Ivoire, however is the density with which prophetic movements have appeared over time throughout Ivoirian territory, their lack of political intensity relative to other parts of Africa, and the strikingly self-conscious references to modernity as a central theme (Dozon 1995). An era of prophesy was

inaugurated with the arrival of the Prophet William Wade Harris on Ivoirian shores in 1913[6].

William Wade Harris was born around 1860 in Half-Graway, a small village in what is now Maryland County, Liberia. At the time of Harris' birth, tensions between American settlers, slaves repatriated by the Maryland Colonisation Society, and native Glebo peoples, ran high. Liberia was still a young country, founded in 1834 by slaves returned from America who named their capital Monrovia after President Monroe. The returnees saw themselves as civilised compared to the "natives," and zealously set about converting heathens. Harris himself converted to Methodist Episcopalianism in his early twenties, after returning from two years as a *kruboy*[7] on one of the English trading ships that plied the Gulf of Guinea. After his conversion, Harris preached and worked as a schoolteacher.

In 1910, Harris was sentenced to two years in prison by the Liberian authorities for his involvement in an aborted mutiny that is thought to have been backed by the British[8]. In prison, Harris became discouraged and briefly returned to the "fetish practice" of his pre-Christian youth. Once in prison:

> some time before June 1910 he was awakened at night and in bed — during a trance — was called by God (of the Bible) through the visitation of the Archangel Gabriel who appeared to him spiritually as a man in a great wave of light. He was told that he was in heaven, and that God was going to anoint him prophet, like Daniel, but of a *modern* time of peace. This God-destined mission was to consist of preaching, fetish-destruction and Christian baptism.
>
> Shanks 1994:115, emphasis added

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[6] Prophetic movements have been reported on the African continent since the mid-nineteenth century, notably in Southern Africa with the. The prophet Kimbangu emerged as a significant political force that considerably worried Belgian colonial authorities in the Belgian Congo in the 1920s.

[7] Having served on British ships since the eighteenth century, some coastal tribes in present-day Liberia and western Côte-d'Ivoire are known as *Krou* or *Kroumen*.

[8] Shanks (1994:91-96) makes the case for Harris' involvement in a coup attempt along with Edward Blyden, the African American colonist sympathetic to the natives who was one of the fathers of pan-Africanism.

Harris did not serve his full term; he was released later on in 1910 on recognisance to an Episcopalian Minister. He preached in Liberia for another three years before setting off on foot with two women companions to spread his message. They travelled east, into Côte-d'Ivoire, on a mission to bring African nations back to God. Exhorting the villagers they met to burn their fetishes and convert to Christ, Harris attracted increasingly large crowds, including a circle of English-speaking interpreters drawn from the clerks who worked at British trading posts along the way. The arrival of the white man in Africa, Harris preached, heralded the birth of modern times. An era of peace would be preceded by a great world war. The white man owed his superiority and technical advantage to the worship of the true God; the black man could aspire to enter history side by side with the white man only if he abandoned his worship of the false gods of fetishism. Harris' message transformed the countryside he travelled through: during the 17 months his mission lasted in Côte-d'Ivoire, over 100,000 people were baptised, and twice that number abandoned the visible signs of traditional religious practices. Harris and his entourage travelled as far as the Gold Coast, before turning back to Côte-d'Ivoire, ultimately being expelled back to Liberia by the French authorities in late 1914.

Figure 3.3 • Photo of Harris

The French authorities were puzzled by Harris, and didn't know what to do about him. Although he was briefly arrested twice on nuisance charges, they were on the

whole rather sympathetic to him as he encouraged respect and obedience to the colonial government; they were favourably impressed by the fetish-burnings and the orderliness he left in his wake. Harris' ability to achieve these results across an ethnically and linguistically heterogeneous territory suggested that he might be useful to French efforts to impose colonial development policies. On the other hand, his ability to mobilise the natives was worrisome. Harris denounced colonial authorities for breaking the law of God, for example by making labourers work on Sundays – colonial authorities were concerned that this might set a precedent for contesting their legitimacy. Harris' journeying had encouraged natives to debate and evaluate colonial practices and policies in light of his teachings, in effect setting up a colonial proto-public sphere. Harris' followers were mainly youths and women, undermining the lineage authority of elders. This had the potential to destabilise colonial efforts at indirect rule that relied on elder's authority. Governor Angoulvant met Harris and was sympathetic to him. However even the Governor's sympathy was not enough, and an increasingly nervous colonial administration finally sent a *Commandant* to arrest him in late 1914 in Bassam despite Harris' warning that the Commandant would die if Harris was arrested. He was deported two months later to Liberia; the *Commandant* died a week after arresting Harris (Shank 1994:3-16).

That Harris' prophecies — the outbreak of World War I and the death of the Commandant, along with a number of other minor ones — came true certainly added to his charisma. His brief arrests and releases led to rumours that he was able to walk through walls and was immune to French authority. But his converts in Côte-d'Ivoire never heard from him again after his return to Liberia. Although he continued to preach in Liberia and then Sierra Leone, this never translated into the kind of mass movement witnessed in Côte-d'Ivoire: "the prophet is without honour in his own country." In Côte-d'Ivoire, two more Liberian prophets followed in his wake, followed by a veritable "epidemic" of religious movements that continue to proliferate to this day. Not all these are prophetic. The "black yam movement" of 1918 seems to have been a quasi-religious form of self-destructive resistance to colonial rule, not unlike the Xhosa black cattle massacres of the mid nineteenth century in South Africa. (The "black yam movement" involved the destruction of the yams favoured by colonial traders, resulting in starvation in parts of the colony.) But all these movements were modern: new forms which consciously engaged the colonial reality. It is as though Harris's

predication, by jolting Ivoirians into a consciousness of historicity, cleared away an undergrowth of ideas and practices — so-called "fetishism" — which were not tooled to apprehend colonial modernity. The vacuum that followed was fertile ground for other ideas and movements to take hold. Catholic and Protestant missionaries, who had seen Harris outstrip them in his influence over the masses by several orders of magnitude over a short period of time, stepped in quickly to fill the gap, at times literally fighting over converts (Dozon 1995).

Harris's legacy is still debated. The Harrist Church, which was founded by converts after his departure, has become a fully established Church, recently admitted to membership in the World Council of Churches. Harrists are a small minority of Christians in Côte-d'Ivoire today, but a significant one, coming a distant third after Catholics and Protestants, and can claim by far the largest membership of the African Christian congregations. There does not appear to be a clear link between Harris and the prophets that followed him and the eventual elaboration of a political movement that would resist colonialism, as has been argued for a number of other prophetic movements in Africa. Indeed, the proliferation of prophetic movements in the postcolonial era and their consistent separation from the political sphere would argue against any determinist reading of prophetism as "resistance." Dozon (1995:62) has noted how, by transcending the present in order to elaborate a vision of a future whose universality stems from an encounter with the Other, Harris's story furnishes a quintessentially Hegelian narrative of History. Following Dirks (1990), it could be said that Harris was the "sign of the modern" in Côte-d'Ivoire.

Figure 3.4 • Harrist processions (Haennger 1983).

The impact of Harrism was not limited to these recurrent epidemics of prophetic movements. The zones of the new colonial territory that fell under Harris's sway in 1913-1915 were those that subsequently were most receptive, not only to new religious ideas (a kind of "prophet belt"), but also to colonial practices of the modern. Harrism was the first social movement to transcend tribal boundaries, a feat that few other prophets were able to accomplish (Holas 1954). Specifically, these were the areas that were quickest to adopt cocoa cultivation and the administrative and familial arrangements conducive to a nascent plantation economy (Dozon 1996). Plantations required sophisticated accounting and planning, as well as a system for guaranteeing large quantities of seasonal labour.

Kinship systems had to be flexible enough to allow cultivators to concentrate claims over their sons or their sisters' sons or, alternatively, these claims had to be loose enough to allow sons to negotiate their labour. Dozon has argued that Harris's influence was not so much to dissolve "traditional" social ties as to engender a reflexive public sphere where the nature of these ties could be negotiated in light of the new colonial reality. It was this public sphere that provided the space from which native politics, in the form of planter syndicates and ultimately the African Democratic Congress, would emerge under the leadership of Félix Houphouët. Dozon has argued that this sphere retained a residual prophetic charisma, imbuing Houphouët's nation-building with prophetic elements.

Augé has gone further, arguing that

> ...the prophetic movements [in the Ivory Coast] constitute an anticipation, if not a prophecy, of...the phenomenon of the global village. Colonised people were the first to experience this development because they were the first to be *subjected* to it. The colonisers, for their part, more or less accepting the evolutionary model and, before that, persuaded that they were the representatives of the universal model of civilisation, never saw anything but a primitive or deformed image of their own identity in the others they confronted; the contact with plurality and difference did nothing to alter their mode of thinking in their relationship with the world. In fact, they actually never had anything but regional or peripheral adventures. Their relationship with universality was never the result of a true experience with plurality. Those colonised, however, underwent a triple, and most frequently painful, experience — the discovery of the other, and which today is something we all share in: the experience of the acceleration of history, of the closing in of space and of the individualisation of destinies.
>
> (Augé 1994:16)

Voluntary associations and *évolué* sociality

Figure 3.5 Group of women (photo by Cornelius A Augustt, 1968, from Haus der Kulturen der Welt 2000).

Anthropologists studying urban life in colonial Africa often remark on so-called voluntary associations, devoting a number of studies to these groups. While most of these studies are in British Africa, voluntary associations are also present in French Africa. The origins of these associations are unclear. The first such association registered in West Africa was founded in Cape Coast (Ghana) in 1787, "for social purposes and to establish a school for the education of twelve mulatto children" (Wallerstein 1964:88). In French Africa, liberty of association, guaranteed in the metropole by the law of 1881, was not granted until 1946. Until then, all groups were obliged to register with the government, which set a significant barrier to the development of an indigenous civil society. Anthropologists viewed voluntary associations as vehicles for adaptation to city life by natives who were otherwise "detribalised" by the urban environment (Parkin 1966). It was widely believed that these groups were a vehicle for social change by providing forums for the articulation and adoption of new values and norms more adapted to city life.[9]

[9] See Anderson 1971 for an overview that argues that voluntary associations are vehicles but not motors of social change; Banton 1965 on 'Young men's companies' and entertainment and bereavement societies.

Many organisations were organised along ethnic lines, focusing on cultural activities such as "tribal dancing," attendance at funerals of members' family, and other social events (Mitchell 1940). In addition, they provided a buffer to the economic insecurity of the city (Little 1962). Membership dues were collected and used to offset funeral costs and occasionally to help out members in need. A significant number were rotating credit associations or "thrift clubs": members would pay in a fixed amount every month, with the total sum collected being paid back to a different member every month. They are believed to have originated in the Yoruba institution called *esusu* (Wallerstein 1964:95). Interestingly enough, these thrift clubs are called *tontines* in Côte-d'Ivoire and are often managed by "walking bankers" of Nigerian origin. These rotating credit associations allowed members to create savings in an environment where it was otherwise difficult to save money. With no access to banks, any capital accumulated was liable to be spent recklessly on the temptations of urban life or, worse, be stolen. These associations functioned on trust, a social capital that was afforded by a shared ethnicity (Ardener 1964:216).

Notions such as "detribalisation," "adaptation" and "urban kinsmen" emphasised the so-called traditional basis of these voluntary associations. However, many anthropologists observed that they were culturally syncretic (Little 1962, Ghickman 1940, Schwab 1970). Alongside tradition one always found modernity. In his classic study of tribal dancing in the mining compounds of the Zambian copperbelt, Mitchell (*ibid*) commented at length on the various forms of European dress of the dancers that parodied Europeans. This, he argued, was a form of satire venting otherwise forbidden resentments at colonial authorities, and an expression of collective identity unified in opposition to the European coloniser. Mitchell and others have commented on how these associations imitated European forms of social organisation, with seemingly undue emphasis on the distribution of administrative titles such as "President," "Secretary," and so on. This, along with the penchant for being "smartly turned out" led observers to conclude that the accumulation of prestige was very much at stake in these associations. This interpretation has been strongly criticised for portraying natives as childish mimics of an assumed superior civilisational order and obscuring the reality of colonial domination which left natives little choice but to assimilate (Magubane 1971). Nonetheless, this work points to the role these associations

played in mediating the colonial experience. They were mechanisms for palliating economic insecurity, but also places of laughter, play, and sociality.

Far less ethnographic data on French African cities is available, with the notable exception of Balandier's *Sociologie des Brazzavilles noires* (1985). French anthropology did not develop a tradition of fieldwork until after the colonial period, and what ethnographies were done, focussed on rural life and were written by interested colonial administrators. Settlers were interested enough in "natives" to write about them only to the extent that they exhibited exotic practices. Students who entered the *École coloniale* in Paris to prepare for a career in the colonies consistently exhibited a desire to flee the conformity of France, serve the Republic, civilise the natives, and learn about exotic cultures. The Africans most equipped to enter the conversation, those who had been educated to become clerks and schoolteachers, and hence were referred to as *évolués*, did not really interest the settlers (Cohen 1971).

Figure 3.6 • "Trois garçons à la mode," photograph by S Keita, circa 1960, from Revue Noire 1998:39.

However *évolués* were the nucleus of a growing African sociality that centred around clubs and cultural activities (Tirefort 1983). Among the earliest were African schoolteachers' theatre clubs, which put on plays. Initially these plays were written by well-meaning settlers who wished to draw on a "tradition" of "African folklore," and produced pieces such as *A marriage in Dahomey*, *Return to the abandoned fetish* or *The interview of Samory and Captain Péroz* whose titles belie a certain colonial pedagogy. At first, the troupes played to audiences largely composed of Europeans, some literate Africans and even curious villagers. Over time, however, the plays became popular with urban Africans who, although largely illiterate, were able to understand spoken French. The practice spawned a contestatory theatre of which only oral traces remain. Passages in "dialect" ad-libbed by the actors provided a space for social commentary. African theatre paralleled the emergence of an epistolatory sociability amongst the *évolués*. Friendships forged in colonial schools were maintained despite postings to far away towns through letter-writing[10].

Sporting associations were actively promoted by the colonial authorities from the 1920s. Eugenicist ideas from the metropole, along with the observation that many Africans had been deemed unfit for military service during conscription for World War I, provided the inspiration for "improving the natives" through sport. Colonial enthusiasm was sufficient to win over reservations that sporting clubs could foment political unrest, on the condition that the clubs be supervised by settlers. Despite investment in playing fields and rudimentary facilities, however, Africans appeared to have initially shied away from the clubs. They preferred the dancing and bereavement societies that were more congruent to their idea of sociability and, besides, could occur discreetly without colonial tutelage. Lack of interest on the part of both natives and settlers meant that many of the clubs did not survive. The 1936 Berlin Olympics were a turning point, the highly visible victories of Black American athletes leading to renewed interest on the part of French authorities who undertook tours of the colonies in search of star athletes (Deville-Danthu 1992). Sporting clubs came to play an important role throughout the colonial period, this time buoyed by generous colonial funding. Skinner

[10] See Jézéquel 1999 on African theatre in AOF; Martin (1985) addresses issues of colonial sociality through leisure activities in AEF's capital of Brazzaville. Hunt (1994) raises issues of colonial mobility, letter-writing and self-fashioning in the Belgian Congo which are further developed in her *A Colonial Lexicon (1999)*.

(1974:266) reports that competition for funding instilled intense pressure amongst athletes, leading to fission of clubs as athletes jockeyed for colonial funding.

Figure 3.7 • Self protrait, © Revue Noire 1998. Doro Sy, photographer, circa 1945.

Whether they were occupational associations, dancing clubs, theatre groups, bereavement societies, or credit cooperatives, these voluntary associations blended traditional and modern: tribal dances and western dress, European literature and African orality, village rites and bureaucratic organisation, rational economics and relationships based on trust. To the European anthropologists who observed them, this proved that voluntary associations were transitional forms, a passage from the traditional to the modern that was at times almost comic with its airs of "make believe" or of brazen colonial mimicry. These associations were thought to be colonial palliatives for their members, thought to be symptomatic of the rapid transitions demanded by colonialism. *Évolués* were best equipped to fashion modernity on settler terms. The fact that European forms — literature, theatre and so on — set the conditions for entering a modernist public sphere, was taken as evidence of African assimilation into a European modernity. In this view, the

medium determined the message, such that African voices could only articulate a kind of derivative modernity.

With modernisation and the transition to a modern society, it might be expected that voluntary associations would fade away. But even at the peak of Côte-d'Ivoire's high modernist decade, these associations persisted. Thoret, for instance (1974) found that youth clubs, with chic English names such as 'the Famous Brothers' the 'Princes of Liberty' or the "Red-Hot Chilli Peppers" proliferated in Bouaké (the second-biggest city after Abidjan) and surrounding smaller towns in the centre of the country. These youth had been to school, as was reflected in the mission that they gave themselves through these clubs: to "modernise the villages" through "literacy, self-help and educating the peasantry." Membership was along ethnic lines, and attested to by handmade membership cards complete with photos and stamps. Dances were open to nonmembers, and were the occasion for youths returning from Abidjan to show off the latest moves, and for competitive behaviour, youths from rival clubs would, for example, try to disrupt the dances by picking fights. As we shall see in Chapters 6 and 8, voluntary associations are a vibrant force today, persisting by recombining the 'traditional' with the 'modern,' both in the village and in the city, and thereby belying earlier interpretations that they were transitional forms that would wither way.

Figure 3.8 • Malick Sidibé, "Nuit de Noël à Bamako," from Revue Noire 1998.

One explanation for the persistence of voluntary associations is that modernisation, in fact, never really happens or is at best partial and always incomplete. But, after Habermas (1987), modernity can always be viewed as an unfinished project, and as the example above suggests, there appears to be more to these voluntary associations than stop-gap measures in an incomplete modernity. The oft-noted mimicry of the state common to these associations suggests that they serve to *produce* tradition and modernity, just as the colonial state did through practices that ascribed ethnicity, to which tradition could then be attributed by both settlers and natives. In so doing, voluntary associations work to position their members in the space where social change is being brought about through the production of these categories. Rather than being a normalising response to the pathologies resulting from colonisation, voluntary associations were collective strategies for mastering social change in both the city and the country.

Conclusion

The colonial state in Côte-d'Ivoire was, relative to other colonial states, a powerful one. Territorialisation required mapping the territory and naming its inhabitants, a process that relied on administrative ethnographic practice. Intensified mobility made ethnicity the currency through which people negotiated social relations in the colonial economy, particularly in the city. As a result, ethnicity was the category through which colonial experience was mediated and natives imagined their relationship to others, the state, and the future. Voluntary associations served as laboratories, where novel social relations drawn from both local and imported forms of social organisation were experimented with, stretching and blurring the boundaries between old and new and effectively re-inventing tradition and inventing the modern at the same time. Throughout, the colonial state was an anchoring reference, an overarching framework that orchestrated representations without the use of physical coercion.

Harris' prophetic mission was a brief but powerful counter-hegemonic moment, in which reflexivity about colonial rule was organised on a new, trans-local scale.

While Harris' preaching cannot be construed as resisting colonial rule by any means, it set the stage for the emergence of a colonial modernity characterised by ethnically differentiated economic strategies, and the emergence of a proto-public sphere from which a nationalist politics would arise.

This historical consideration points to how, under colonial domination, "subaltern agency" might be manifested in tangential ways. Although it is beyond the scope of this analysis to consider to what extent voluntary associations, prophetic spaces, and native appropriations of colonial ethnic categories constitute the exercise of historical agency, these phenomena indicate that contemporary anthropological discussions of resistance and agency must be mindful of the historical embeddedness of such tangential practices. This view is congruent with other anthropological work that has problematised the historical dimension of agency (see Comaroff 1985, Comaroffs 1991, 1992), particularly in the context of colonial governmental practices (Thomas 1994), and a too-readily perceived equivalence between "resistance" and pragmatic action (Lock and Kaufert, 1998). These issues will be explored in more detail in the ethnographic section of this dissertation (chapters 6 through 9). Mobility, and the territorialisation of state power conditioned novel social spaces — prophetic belts, urban forms of sociality — that give a more differentiated picture of the African response to social change in the colonial period. This indicates that contemporary considerations of social change will need to be attentive to these spatialised dimensions of social life.

Chapter 4
Practices of the modern and the Ivoirian postcolonial state

Introduction

This chapter focuses on the Ivoirian postcolonial state's program of modernisation. It will argue that, while incomplete, this program still resulted in profound social changes and cultural forms that persist to this day. These changes shaped the way individuals understood the world they lived in, made tactical choices, and thus behaved. Sexuality and illness, and in turn sexual behaviour and patterns of resort, were conditioned by this modernist culture, with important implications for the AIDS epidemic that will be further explored in Chapters 5 and 6. But first, the historical and economic origins of modernisation, and its social impact, will be explored.

In the colonial period options — and possible futures — were few, limited to manual labour (on plantations or the railway), trade, or colonial service. Furthermore, how one would imagine one's strategy for material survival — as a labourer or a clerk — was conditioned by ethnic identity, as attributed by the colonial state (chapters 2 and 3). The postcolonial state's modernisation program emphasised schooling, urban planning, and the development of all the apparatuses of a modern nation-state. As will be shown in the next chapter, the programme fell short of its objectives with the economic crisis triggered by a dramatic collapse in commodity prices in 1979. This event created a gap between the social modernity that the postcolonial state's modernisation programme failed

to achieve, and the cultural modernity it reflected. With the economic crisis, the state's "promissory notes" (Wittrock 2000) — notably the benefits of education and modern health care — became worthless as institutions were hollowed out by structural adjustment. However, a cultural modernity fostered by socio-economic modernisation had already translated into the Ivoirian imaginary. Ivoirians continued to imagine their fate and construct their lives around individual choices, whether these concerned schooling, economic strategies or romantic relationships. This individualisation persisted even though the premises under which it had been engaged — a "modern" economy — no longer existed. The gap between the expectations Ivoirians had of modernity and everyday life was experienced as an uneven, or incomplete, modernity. It is in this gap that social change was most strongly felt and acted upon. This will be the subject of the next chapter.

Habitat and mobility, the key indicators of social transformations in the colonial period, remained registers of change in the postcolonial period. As seen in chapter 2, during the colonial period, colonial domination and its ancillary practices of government constrained housing and mobility in new ways. After Independence, the postcolonial state enacted a program of modernisation that laid the groundwork for a modern society and a modernist culture. Housing and mobility provide evidence of an emerging Ivoirian modernity characterised by rationally differentiated strategies of land tenure and housing choice, and increasingly diversified migratory strategies. Even the "informal" housing outcome discussed above was subject to rational management — bulldozing — by the State. Mobility was driven by complex and heterogeneous concerns, which included economic opportunities, access to education and family relationships. This reinforced individualisation, as reasons for moving were increasingly differentiated according to individual aspirations. As the social terrain became more textured, both because of the capitalist development of the economy and because of the proliferation of state institutions, individuals were presented with an increasing array of futures to imagine. Fate, in other words, was individualised.

A brief history of post-war Ivoirian modernisation

After World War Two, the French Fourth Republic, under the initial impetus of Charles de Gaulle, who was grateful for African resistance to the Vichy régime, gradually granted limited representation to the colonies under a complicated system of graduated voting rights and territorial chambers, formalised in the Loi cadre of 1956. While only certain Africans could vote and their representatives in the French National Assembly were few, the factional politics of the Fourth Republic, with its shaky coalitions and revolving-door governments, offered good political training for Africans sitting in the National Assembly. Parliamentary immunity allowed African MNAs to engage in nationalist political activity with relative impunity (Zolberg 1969:92). The legislative parameters set by the French set the stage for the emergence of a nationalist political movement, headed by the charismatic physician and planter Félix Houphouët-Boigny. Houphouët established his political credentials as leader of the African planters' union. Houphouët was able to score a string of political victories culminating in his nomination in 1956 as French Minister of the Colonies, succeeding François Mitterrand in the post. In 1961, after four years of limited self-rule within the French Union, Côte-d'Ivoire became an independent State.

Figure 4.1 • The "radical" Houphouët in 1950.

Houphouët was a modernist through-and-through, especially compared to his rival for postcolonial fame, the arguably romantic Senegalese President Léopold Sédar Senghor who was one of the founders of the *négritude* movement and a renowned poet, who wrote in French. Initially, Houphouët embraced the modernist Left, cultivating ties with the French Communist Party; as a result, the French establishment worked hard — at times using political violence — to isolate the radical Houphouët between 1946 and 1951. Houphouët made an about-face in 1951, orchestrated by Mitterand, which led him to embrace liberal economic ideas. After this virage, he remained a staunch supporter of France, admirer of French institutions and defender of Gaullism. Under Houphouët, Côte-d'Ivoire's First Republic embarked on a resolutely modernist program of urban planning, state intervention into the social realm, and economic liberalisation[1]. Côte-d'Ivoire was an exception in Africa in that urban policy was a key element of the national development strategy (Cohen 1974). Abidjan's urban plan was emblematic of the postcolonial state's "high modernism," that is, its privileging of the aesthetic forms of modernism — signalled by the city's grid pattern and preference for skyscrapers — and the desire to fashion a legible social order[2].

[1] Houphouët's great rival was neighbouring Ghana's equally modernist Kwamé Nkrumah, who embraced pan-Africanism and saw the role of the State in much more socialist terms. Houphouet's program was explicitly advanced as an alternative to Nkrumah's Ghanaian option.

[2] The relationship between "high modernism," social legibility and state practices is drawn from Scott 1999, and is returned to later in this chapter.

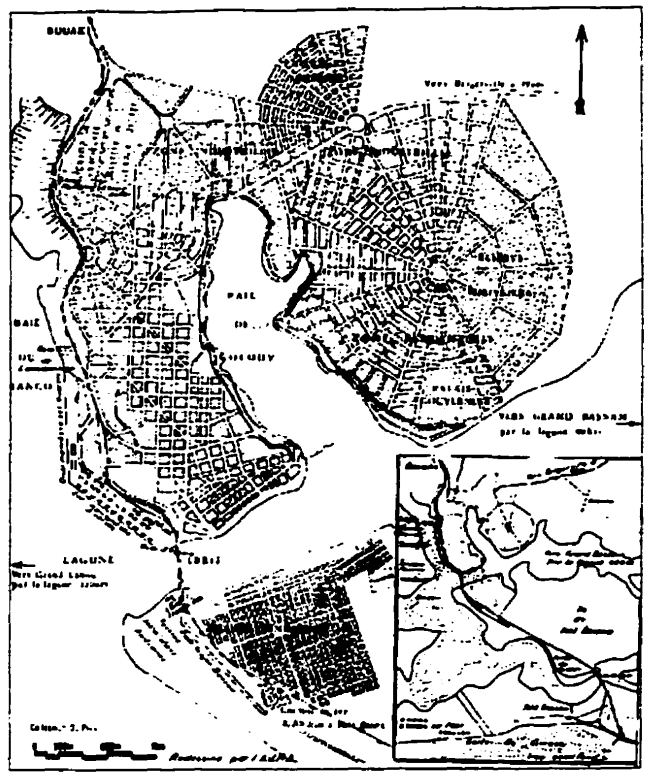

Figure 4.2 • Grid map

The opening of Abidjan's deepwater port in 1950 heralded a decade of unprecedented economic growth, allowing it to overtake rival ports along the coast. As a result, the gross domestic product (GDP) increasing by seven to eight per cent per year. With Independence, the new postcolonial state's budget increased by 158%, boosted by the cessation of economic transfers to the poorer colonies of the federation that had begun with the 1956 reforms of the Loi cadre, supported by Houphouët and, not surprisingly, opposed by poorer Sénégal's Senghor who warned of the dangers of "balkanisation" (Fauré 1989). Houphouët led the postcolonial state in a single-minded pursuit of economic growth and modernisation, a reasonable ambition given the economic performance of the colony, its natural and infrastructural assets, and the political dividend of independence. The strategy for modernisation was to generate growth through the intensification of plantation agriculture, which was diversified to include palm oil, rubber, bananas, pineapples and other citrus fruits. This was to be afforded through foreign investment and foreign labour. The strategy paid off for twenty years, resulting in the "Ivoirian miracle." During the miracle years the economy continued its dizzying pace of growth. The urban physiognomies of the new

capitals of Dakar and Abidjan reflected their respective national Presidents' sympathies: Senghor's Dakar conserved its tasteful colonial appearance, while Houphouët's Abidjan became a brazen icon of urban modernity, complete with towering office blocks, freeways, bridges and a strikingly modernist cathedral.

Figure 4.3 • View of the Plateau from the *220 Logements*.

However, the reliance on foreign investment prohibited the development of an indigenous capitalist class (Fauré and Médard 1982). While the French population in their former colony quadrupled and investment skyrocketed, Ivoirians remained petty landowners, with the state being the only indigenous institution able to invest significant amounts of capital. Attempts to use import substitution policies to develop local industries failed to develop a significant, autonomous industrial base in the new country. Industrialisation was limited to the production of consumer products whose manufacture required importation of expensive commodities. These were affordable largely because the currency in use throughout ex-French West Africa, the CFA franc, was — and still is — pegged to the French franc. The Ivoirian economy was like a house of cards propped up on the value of its exports. When export commodity prices collapsed in the late seventies, the cards collapsed and the miracle evaporated (Duruflé 1988).

As we will see in chapter 5, from the early eighties on, the country entered a long and painful period of economic decline. This was initially referred to as "the conjuncture," and then "the crisis," as the State retrenched under the aegis of the World Bank and IMF-mandated structural readjustment programs. Social spending was slashed, and the "modern" sector of the economy shrank. The number of unemployed and, as a consequence, the importance of the informal economy grew. However the crisis did not erase the social and cultural impact of the modernising drive of the state.

Housing and the production of the social

Habitat and mobility were emblematic of the colonial situation (cf chapter 2). Here was where the social transformations of colonialism registered most strongly and most consistently, both at the level of individual experience (how Africans perceived and underwent colonialism in everyday life) and institutional practices (the collective responses to the colonial situation, whether in terms of colonial authorities or indigenous organisations). Of course, neither housing, mobility nor social change itself were new under colonialism, but colonialism, the entry into a monetarised capitalist economy, and the urbanisation it spawned, transformed each of these factors in a scale and intensity that was unprecedented. While the workplace and the school might be more obvious places to look for social change, being classically "modern" institutions, quantitatively fewer Ivoirians were exposed to them. Housing and mobility were ubiquitous[3].

[3] Mobility's ubiquity is testified to by historical, ethnographic and demographic accounts: see below

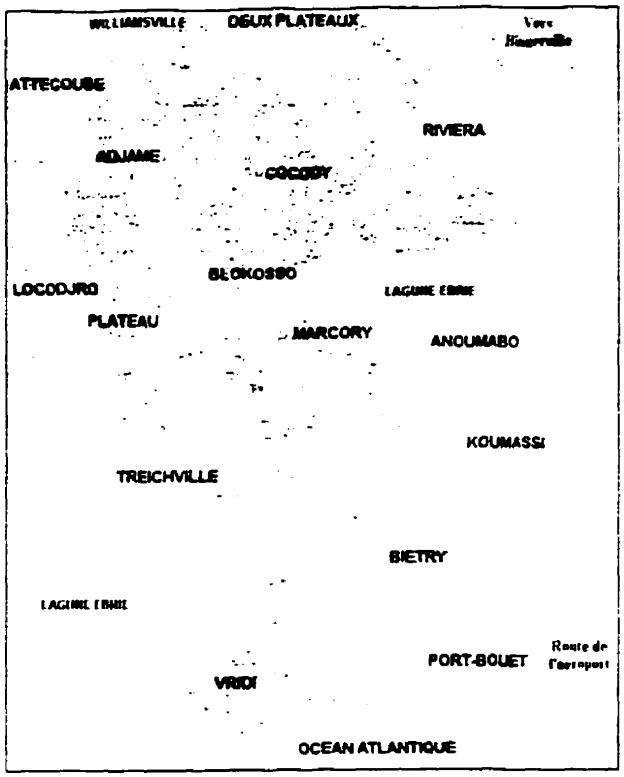

Figure 4.4 • Map Showing Treichville (site of the old Anoumabo, which was across from the Plateau between the 2 bridges) and new Anoumabo, north of Koumassi.

After World War II, and in the postcolonial period up until the crisis of the late seventies, housing ceased to be a site of open confrontation between the state and urban dwellers. However, as the issue of housing became increasingly tied to the market economy it emerged once again as a social issue. In earlier times the colonial state's role in native housing was limited to the ordinances aimed at channeling the growth and form of unplanned housing. In 1948, ordinance number 220 recognised that Treichville, the former Ébrié village of Anoumabo across the lagoon from the European quarter of the Plateau named after the French explorer Treich-Laplène, (see chapter 2) should be reserved for Africans. There, the ordinance granted Africans full property rights over land which had already been used for habitation — as long as it had been built over. Treichville had always been an African quarter, and was now located in the heart of the expanding city, between the old commercial and administrative district of the Plateau and the new industrial zone along the port which opened in 1950.

Figure 4.5 • Treich-Laplène (Diabaté, n.d.).

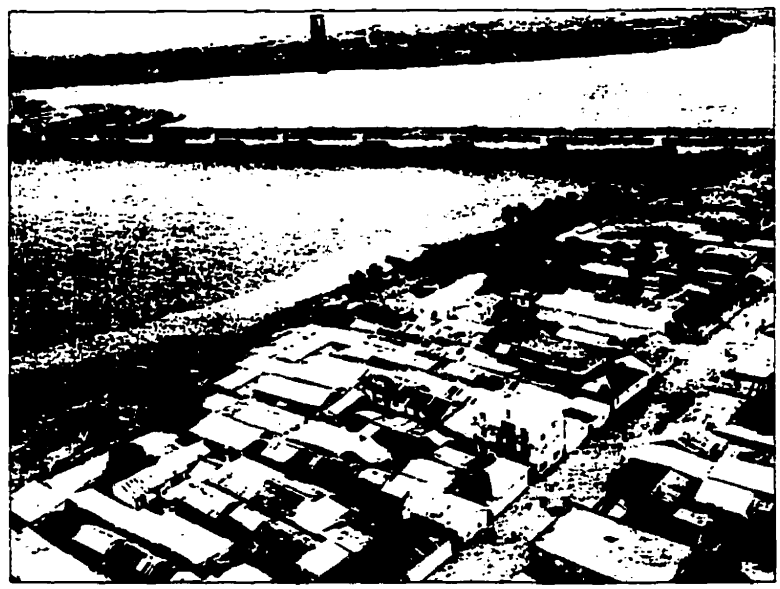

Figure 4.6 • Old Anoumabo in the early 1960s, before it was razed to become Treichville (Diabaté, n.d.).

Some Europeans attempted to have the ordinance revoked, in order to have access to the housing market near the core of the city. While they were ultimately

unsuccessful, Europeans' demands highlighted the precarious situation of African renters who would be easily dislocated should they have to share the same housing market with Europeans. This precariousness was a problem for the colonial economy. Colonial authorities worried that continued *déguerpissements* — evictions — might lead to workers' deserting the city, causing a labour shortage. As workers moved further and further out, they would have to pay more, and spend more time, to travel to their workplaces. Staying closer to town required rents they could not afford. No matter what decision was taken, either labour costs would have to increase or there would be a risk of social unrest — a concern sharpened by the brief 1938 railway workers' strike over housing conditions.

Cognizant of this precariousness, in 1951 the colonial administration established a state-owned housing corporation, *the Société immobilière d'habitation de Côte-d'Ivoire* (SIHCI), to build economical housing for native workers. The first public housing in Abidjan built by SIHCI was divided into three types: cheaper collective housing for labourers, built in the *cours commune* style with rooms around a common courtyard, kitchens and toilets; smaller apartments for the intermediary class of "boys" — domestic servants — and chauffeurs which could accommodate a small family; and more spacious apartments for African white-collar workers. The design of the housing, as well as its price, was determined by an all-settler commission of the *Société* on the basis of anecdotal evidence: what the members of the commission knew — or imagined — about how Africans lived. Believing that poorer labourers lived either alone or "traditionally" in extended families, cheaper, collective housing units were built for them. The commissioners also assumed that wealthier salaried personnel — clerks and middle managers — would be more "modern" and thus prefer to live like Europeans with their smaller families in more comfortable, and expensive, apartment units. (Le Pape 1997)

The reality was the contrary. Labourers, being poorer, lived most often in a nuclear family, while wealthier workers were able to support much larger extended families. The commission fixed the prices of the dwellings as a function of wages, putting the collective housing beyond the reach of labourers. The only Africans who were able to afford the new public housing were the few salaried workers who limited their expenditures to a nuclear family. The collective units went largely unoccupied, while the apartments were rented by wealthy Africans who had not been the intended beneficiaries of the SIHCI's social housing. As a

result, the SIHCI's efforts ended up benefiting the élite where it had originally been intended to offer subsidised housing to a representative mix of the African population. As we shall see, it was a pattern that was not to change. (Ibid)

Was the case of the SIHCI just an odd historical side-effect, an ill-conceived first attempt? In fact, it was representative of how housing policy worked to create the social reality it imagined. Presumably, if housing authorities had obtained good data on African households then they would be able to adjust public housing projects accordingly. This was in fact the strategy subsequently undertaken — the first household census in Abidjan occurred in 1956, but was immediately confronted with a practical obstacle. How to define the household? The French census of 1954 had established the unit under observation as those who lived within a single, material residence — obvious enough, it seemed. But, unlike in France, in Abidjan most Africans lived in cours commune, where the boundaries of the household, and indeed of the material residence itself, were blurred and shifted constantly. As a result, statistics about poorer Africans might be expected to generate a reasonable snapshot, but only if the observer was consistent. This itself was not easily achieved. The problem was, how to elaborate criteria about where one household ended and another began that could cover the almost endless permutations of building styles and living arrangements? And, how could observers be relied upon to be consistent? These problems were never satisfactorily solved. As a result, surveys were notoriously unreliable for tracking changes in household behaviour — it was never clear whether change could be attributed to shifts in household behaviour or in the household itself, which could have become completely different over time.

Figure 4.7 • The "220 Logements" complex's first building in the early 1960s.

One attempted solution was to base a survey on family units — that is, to count all the members of a family as one household, even if they did not live in the same house. Two surveys conducted in 1963-64, just after Independence, used different methodologies. One counted people living in habitation units as households (cohabitation units); the other counted people who were related to an index case as belonging to the same household (family units). Comparing the two surveys, family units were found to be **smaller** than cohabitant units, an observation which ran counter to European common sense about Africans living in large, extended kinship networks. Assuming that respondents were under-reporting their kinship relations, surveyors stuck to the household method. In fact, respondents were not underreporting: most urban dwellers do live with people they are not related to — servants, apprentices, children of friends and so on (Le Pape 1997:63-64), whether they are rich or poor, and the number tends to be greater for wealthier households who are able to support more dependents and employ more servants (Gibbal 1974a:83-85).

It is tempting to regard these as epiphenomena of late colonial rule, part of the legacy of botched schemes, crazy ventures and social blunders inherent in the project of expanding empire over an unruly mass. However, the same phenomena amplified in the postcolonial period from 1961. Designing and implementing a modern urban plan, even when this attempted to take into account the imagined local reality of Africans, was analogous to earlier colonial practices of

ethnographic mapping (chapter 2). The project of a legible social order was common to both. And in both cases, these projects created the categories through which the population constructed society. However, the sheer scope of the massive, postcolonial, program of housing construction dwarfed the tentative projects of the colonial state — it was nothing short of an attempt to create a modern society (Le Pape 1997). Housing was to be a key pillar of State-driven modernisation:

> Supported by vigorous economic growth, the State's housing policy was conceived as a rapid path to modernity, as well as a means to assuring social stability by using housing to redistribute the fruits of national growth.
>
> Dubresson and Yapi-Diahou 1988:1085

The blueprint for the postcolonial state's housing agenda was the city's first Plan d'urbanisme begun by Badini in 1948 and ratified in 1952; a subsequent plan (the Plan SETAP, named after the bureau that developed it) was submitted in 1960 (Figure 4.8). These were the master plans outlining the direction in which the city should grow and the scope and location of public works projects for supporting that growth. After independence, the program of heavy public works investment in the capital reflected the desire to provide the city with a Western infrastructure to attract investment; perhaps not coincidentally, it was the political and bureaucratic élite, overwhelmingly concentrated in the city, that benefited first from these investments (Le Pape, Vidal, Yapi-Diahou 1991:1-9). The plans took into account the city's alarming growth — at that time the population was doubling every six years[4] — and relied on demographic projections to detail significant public investments in housing.

[4] Growth would actually accelerate during the boom of the sixties and seventies. Despite a subsequent slowdown with the crisis of the nineties, the city's population in 2000 is estimated between 4 and 6.6 million, either way a far cry from the 3 million predicted at the time of the *Plans d'urbanisme*. See Roland et al 1969:26. Interestingly,although the city actually grew faster percentage-wise during the colonial period. This did not emerge as a 'planning' problem then — likely because colonial authorities never conceived of the growing urban masses as other than cheap labour that had to be disciplined temporarily through the ordinances described in Chapter 2.

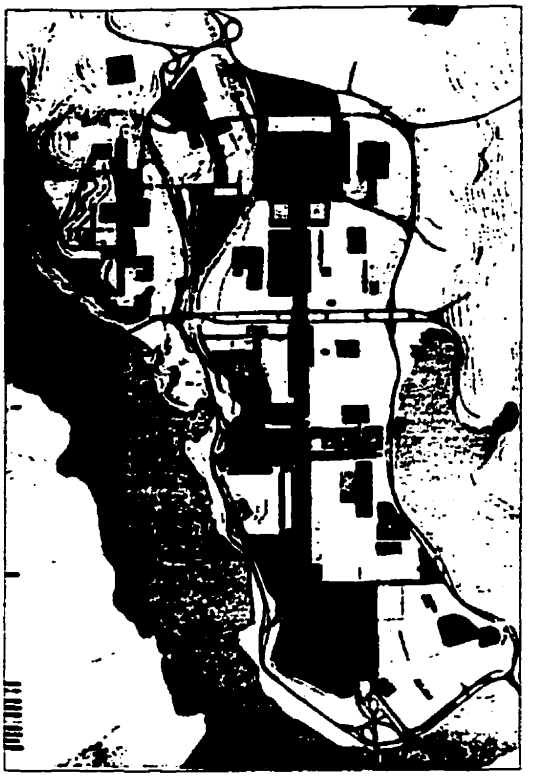

Figure 4.8 • The plan Sétap of 1960 showing the model for the plateau district.

Housing development in the 1960s, however, was to be more methodical than the SIHCI's first attempt ten years earlier. A "vast programme of socio-demographic surveys" was undertaken by a battery of agencies from 1962 to 1964 under the aegis of the Planning Ministry; the data from the studies were processed between 1964 and 1967 with the final result being a detailed action plan and program of state investments (Roland et al 1969:26). The surveys indicated that most Abidjanais lived with non-family members, a fact taken by the surveys' commissioners to indicate that a housing shortage had gripped the city, forcing Abidjanais to live with strangers — when this was, in fact, a normal pattern of urban existence, as noted above. Massive investment in individual housing was prescribed as a remedy. Eventually, thousands of individual housing units were built.

However, as Le Pape has pointed out, the surveys were internally inconsistent, with wildly different results according to which methods were used. Survey methods were simplistic, thinning the dynamic realities of urban life, and resulted in a misreading of the social world of Abidjanais. This can be seen by comparing

the plan with knowledge other administrative services that were also explicitly concerned with describing the reality of urban life in the fifties and sixties. State agencies concerned with the economy generated statistics and reports on trade and markets, while the police and the judiciary wrote extensive reports on the problems of everyday life. A different picture emerged from these administrative representations, whose case studies of petty truancy and detailed depictions of market prices reflected the different practical and epistemological concerns and methods used to address them by these services. Overall, comparing them evokes the proverb about blind men feeling an elephant. Unlike the judiciary and the economists, the urban planners, in association with a battery of social scientists, literally constructed their own social reality (Le Pape 1997:65-67). But was this of any practical significance? What exactly was the scale — the quantitative significance — of the State's efforts to modernise habit in the city?

Figure 4.9 • *220 logements* in 1960.

Two years after independence, in 1963, the State housed 10% of Abidjanais in 6,000 units. Eight years later, in 1971, this had doubled to 12,000 units and 20% of housing respectively. By 1979, on the eve of the crisis, an astonishing 22% of Abidjanais lived in State housing. But while we associate public housing with low-income tenants, in Abidjan the situation was precisely the reverse. Middle and upper income families benefited from the new construction, as the proportion living in private "formal" housing shrank. Meanwhile lower income residents

remained "piled" into the "spontaneous" housing sector, which actually grew during this period: from 51% in 1963 to 59% in 1978 (Armand 1988:265; see also Dubresson and Yapi-Diahou 1988). In the late seventies, under pressure from the World Bank and the United States Agency for International Development (USAID), the State withdrew from the housing sector. The Bank judged the State policy as noncompliant with international liberal norms, and worried that the housing policy might lead to social unrest as a segment of the urban population living under the constant threat of eviction in the cramped insalubrious housing of the "spontaneous" housing sector increased, posing a threat to capitalist investment in the country. (Le Pape, Vidal and Yapi-Diahou 1991:10-11).

Figure 4.10 • Informal housing built on State land (note the billboard: "construction forbidden")

The "spontaneous" housing sector was not the "traditional" counterpart of the modern sector. It developed along two lines, a strategy that Haeringer (1969) has called one of "double or nothing". Fully aware of the legal precariousness of shantytown constructions and of the tangible risk of demolition, dwellings were shabbily built, often of materials recycled from the port. Over time, the construction of such "precarious" housing was quasi-industrialised: the construction-destruction process was simplified using standardised wood materials that were easily transported, assembled and, if need be, disassembled. It took three days to put up a house (Dubression and Yapi-Diahou 1988:1091). This was the 'nothing' option: if the shantytown was demolished, losses were minimal:

either the materials had been obtained free of charge or one could carry them elsewhere.

Figure 4.11 • The 'double' option: impromtu modernist housing in Abobo.

Figure 4.11 • The 'nothing' option: housing made from recycled materials could be quickly disassembled.

The 'double' option was unique to Abidjan. Urbanites whose income allowed them to aspire to owning a home, but who did not have the contacts to get into

government housing, invested in building self-consciously modern neighbourhoods. Concentrating in the fast-growing district of Abobo north of the plateau (see fig 4.11), these ersatz modernists purchased land illegally from its owners (since colonial times, only the State had the right to compensate traditional land claims or expropriate cultivated land for the purposes of urbanisation — see Chapter 2), hired private surveyors to lay out a street grid, and built "modern" houses out of durable materials. It was a significant risk, since modern building materials were expensive. The quarter grew significantly in size through the seventies. In 1980 the State razed the quarter of Abobo-Avocatier, a subdistrict of Abobo, one of the new 'spontaneous' modern quarters, and with it an estimated 2 billion CFA francs (roughly equivalent to 2 million 1980 Canadian dollars) of private investments by individual owners (Cazemajor 1981).

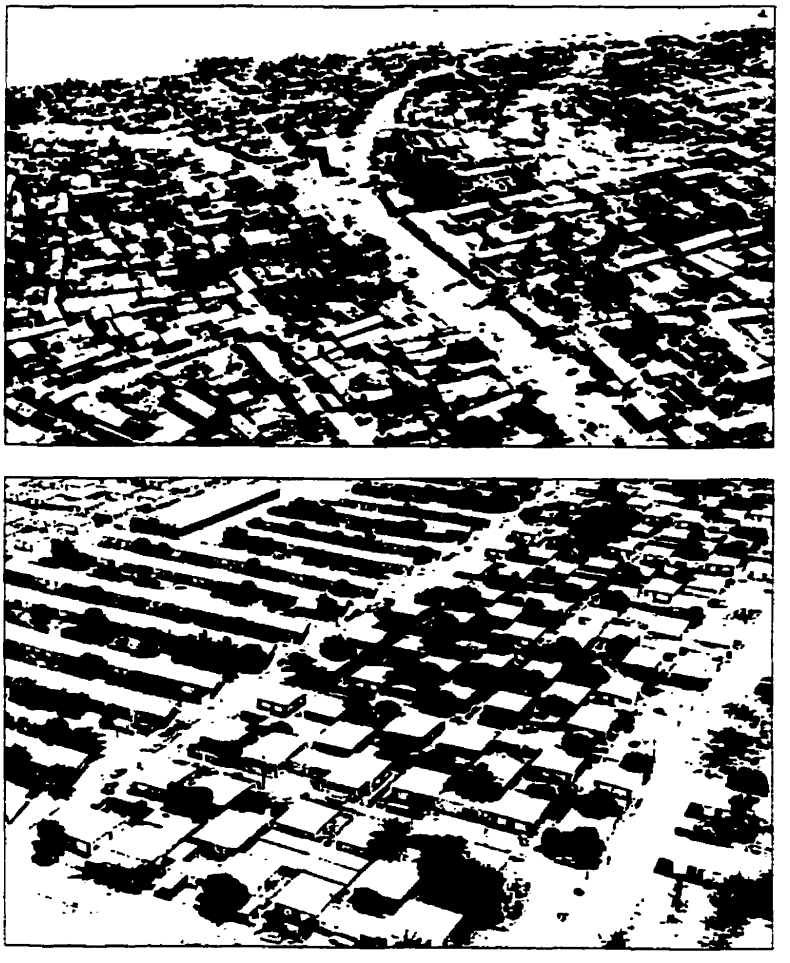

Figure 4.13 • Port-Bouët township. Before and after its modernisation by state housing authorities (Diabaté, n.d.).

The results of this "informal" modernist housing strategy were mitigated in the end, underlining the apparent irrationality of urban dwellers investing considerable sums in such juridically precarious projects. Destruction of modernist illegal housing eased in 1980, partly because of pressure from the World Bank, and the public housing corporations were privatised. Modern State housing units whose construction and rent had been subsidised, fetched far higher prices on the market, increasing housing inequality, driving even households whose income was earned in the "modern" sector into the informal housing market (Dubresson and Yapi-Diahou 1988, see chapter 5).

During the sixties, however, intoxicated by a buoyant economy and the first flush of independence, the city was in the grips of a high-modernist fever. The *plans d'urbanisme*, with their clear grids, only tell part of the story. Clean modernist office blocks were going up throughout the Plateau, and considerable investments had already been made in planning for and designing a "triumphal throughway" that would cleave through the Plateau, flanked by Le Corbusier-like office blocks and linking with freeways that would clear traffic from the eastern and western flanks of the city (see below). Routes for an eventual métro were drawn, and models for a complex of luxury resort and housing neighbourhoods grouped around the lagoon linked by monorail were lavishly displayed. The four-fifths of Abidjanais whose housing was outside the State sector were living in a kind of modernity too — whether they self-consciously imitated the State's modernist style to avoid eviction, or whether they lived in the pre-fabricated shantytowns easily disassembled and reassembled elsewhere should State bulldozers threaten to raze them. Relative to the colonial housing situation, the postcolonial state had effectively modernised poverty: thus, an uneven 'modernity' was enacted through housing, both in and through State practices of urban planning and in the way these were appropriated in differentiated ways through individual initiatives.

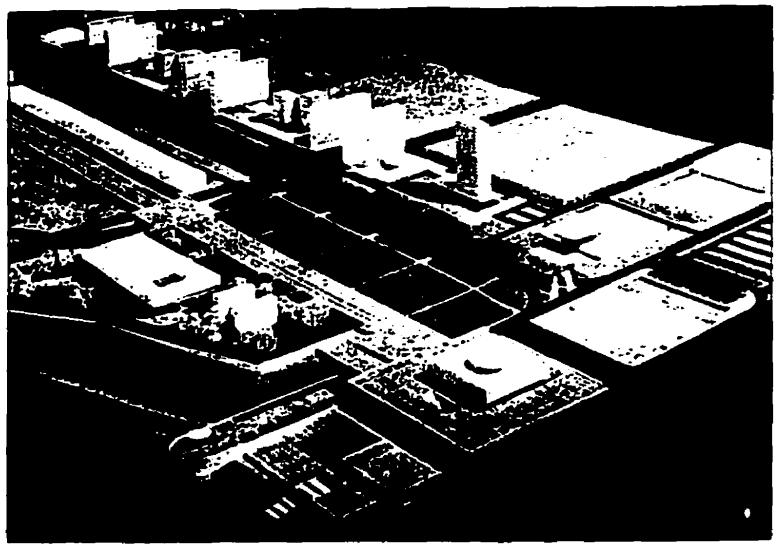

Figure 4.14 • A modernist *Champs-Élysées* in Africa: the planned "*avenue triomphale*"

Public housing served to create the society it imagined it was housing. Although the SIHCI commission's theory of African society was inaccurate, when put into practice Africans constrained themselves to what was available. Those that didn't fit the model — or in this case the housing at the price it was available — remained outside of the state's ambit, crowded into spontaneous housing. Those that did moved into the clean, rectilinear and modern homes of the SIHCI and its poscolonial succesors, the SICOGI and SOGEFHIA (Le Pape 1997: 55-58). Attribution of housing was initially made not solely on the basis of economic merit — modern housing was reserved for State employees or those with the symbolic or financial capital to persuade the housing authorities. Just as the segregationist ideologies of the colonial period had zoned Africans far away from Europeans into insalubrious quarters, thereby fulfilling the prophecy of the dangerously diseased native, these postcolonial preconceptions about the 'traditional' and the 'modern' validated themselves in the way they zoned space and obliged Africans to conform to the material reality they constructed. While in the colonial period, local disease ecologies shaped the representations that produced urban space (chapter 2), in the postcolonial period urban space was the enactment of a culture of modernism.

Scott (1998) has referred to the ensemble of practices through which States have sought to tame nature and order society as "high-modernist," and characteristic of "seeing like a State." Scott sees in "high-modernism" the aesthetic realisation of

Enlightenment rationality and domination of nature. He has shown how these practices thinned the complex reality of nature and society to the point that they doomed the projects they aimed to realise, although he omits to consider those high-modernist projects which arguably have not failed: public health, for instance. The argument assumes that local knowledge and practices, defined as "thick" after Geertz (1973), pre-existed the State, which then "thinned" them.

In this case, the housing interventions of the postcolonial Ivoirian state show that State practices actually diversified and thickened "local knowledges," effectively creating an urban society. Abidjan's postcolonial growth illustrates what Rabinow (1989) has called "French modern." In nineteenth-century France, "norms and forms" constructed through discourses of nature and society (such as biology and sociology) served to create society through the vast array of mediating practices — "middling modernism" — to be found in urban planning and public health. In this the colonies served as laboratories. Roughly a century later, the same procedures can be seen in the modernist drive of the Ivoirian, postcolonial state. Significantly, in the immediate postcolonial era under Houphouët, the number of French citizens in Côte-d'Ivoire grew, as the bureaucracy swelled with technocrats imported to implement the state's modernisation programme. So much so that the Ministry charged with carrying out the modernisation programme, the *Ministère du Plan* (Planning Ministry) was nicknamed the *Ministère des Blancs* (the Whites' Ministry; Dozon, personal communication). The same ideas and practices that were deployed in modernist urban policy in Abidjan were implemented in the planning and construction of the villes nouvelles on the outskirts of Paris.[5]

Demography

The colonial moment was one characterised by an acceleration and intensification of migration in response to forced insertion into a capitalist economy. As seen in the pevious chapter, once the channels of migration were laid down — the railways and roads which lowered the resistances to the push and pull forces of the colonial economy — Africans actively engaged with this colonial economy of

[5] Ironically, *villes nouvelles* such as Evry, Cergy-Pontoise and Noisy-le-Grand are currently heavily populated with North and Black African immigrants and home to tremendous social problems.

mobility. Both domestic and international migration fuelled urbanisation, and particularly the growth of the regional metropolis, Abidjan. Postcolonial demographic studies that will be explored in greater detail below show a synergistic relationship between urbanisation and migration. Migration drives the growth of cities, and increasing urbanisation fuels migration back and forth from city to village. As this cyclical to-and-fro migration intensifies in frequency, it becomes more accurate to speak of mobility.

While no longer 'pushed' by poll taxes or forced labour, after independence in 1961 it was largely the same groups that migrated to the powerhouse of the regional economy. Burkinabè and Malians have consistently made up the largest group of international migrants (see Table 4.1 below). Other neighbouring countries followed, their order of importance fluctuating as political and economic conditions shifted in the country of origin; for example, the outbreak of civil war in Liberia after the 1989 overthrow of President William Tolbert, triggered by structural readjustment-mandated cessation of rice subsidies, led to an enormous influx of Liberian refugee migrants throughout the nineties.

No systematic demographic studies were carried out before World War II, and what surveys were done are considered unreliable. Figures relating to the population growth of cities paint a picture of steady growth, as discussed in Chapter 2. The first "scientific" census of the city was conducted in 1955 (Le Pape 1997:60), heralding a spate of more detailed studies on the household which began in 1958 and intensified in the early sixties, including a study of the population of Abidjan in 1963 (these studies are discussed above). A full, national census — the *Recensement général de la population* (RGP) — was not conducted until 1975 and a more detailed "one-two" census, with every household visited twice, the *Enquête à passages répétés* (EPR) was conducted in 1978-1979. This type of census was able to capture migration within the population. A second, single-passage, census (RGP) was conducted in 1988. A third census was conducted in 1999. The results from this latest survey are not yet available; however, they are already widely rumoured to be unreliable because of inadequate execution and political interference[6].

[6] It is said that this census deflated the population of the North and inflated that in the South in order to favour President Bédié's chances of engineering a positive outcome in the 2000 elections.

As a result, demographers have derived conclusions on migration largely on the basis of the 1960 household surveys in Abidjan and the 1978-1979 EPR. From these, a portrait of a highly urbanised society emerges; in fact, Côte-d'Ivoire is likely the most urbanised and most rapidly urbanising political entity in West Africa (Chaléard and Dubresson 1989). While it is estimated that before World War II less than 3% of the population lived in "urban" zones (as defined by towns with a population over 10,000), this climbed to 15% in 1958, 32% in 1975, and is estimated to reach 60% in 2000 and between 70 and 85% in 2010 (Ibid) Growth accelerated markedly around independence, in the decade between 1955 and 1965; during that time, two thirds of growth went to existing cities and towns while one third flowed into villages which had been designated as administrative centres with the advent of the First Republic in 1961, swelling them into important subregional towns.

This urbanisation has been steadily distributed between regional cities and Abidjan, whose share of the population stabilised at 40% of the national population in the late seventies, when the economic crisis (see chapter 5) slowed its growth and brought it in line with other urban centres[7]. National surveys divide the country into three zones: the Northern "savannah" zone, the middle "forest" zone, and the southern "coastal" zone. A distinct geographic pattern has held throughout. Migration has flowed from rural and urban savannah into forest and coastal urban areas with a resultant net loss in the savannah zone. The forest zone has overall remained demographically stable, migratory flows to coastal areas being compensated by in-migration from neighbouring countries and rural and urban savannah (Dureau 1985:297). However this is not a one-way flow; in fact, migration is back and forth between and within points of origin and destination (Chaléard and Dubresson 1989:281). The EPR revealed that fully one third of Ivoirians migrated over the one year span of the study. This statistic holds across studies of migration in Abidjan (ibid). In 1975, 79% of Abidjanais were born outside the city and 41% were non-Ivoirians; this decreased to 59% and 38%

Bédié's ouster in the Christmas 1999 coup has of course complicated the interpretation of the census.

[7] It is important to add that part of this slowing was due to strictly mathematical reasons. As the urban proportion of the population grows, rural-urban shifts decrease in relative importance — although absolute numbers may actually be increasing.

respectively in 1988 (Zanou and Aka 1994:21). As a result, Abidjan cannot be considered in isolation of its "hinterland," which includes the rest of Côte-d'Ivoire, and also neighbouring countries and Europe (see Table 1 below). The picture painted consistently by demographers and throughout statistical surveys is that of a most extraordinary migration.

Table 4.1 • Foreigners in Abidjan according to National Census[8]

Country of origin	1975 RGP		1988 RGP	
	#	%	#	%
Burkina Faso	157 188	41	275 040	38
Mali	83 507	22	166 496	23
Nigeria	24 539	6	32 096	4
Guinea-Conakry	20 827	5	57 913	8
France	19 640	5	1 472	0,2
Ghana	16 293	4	52 706	7
Sénégal	13 291	4	23 527	3
Niger	13 156	3	31 319	4
Bénin	13 137	3	29 274	4
Togo	8 648	2	24 060	3
Lebanon	2 915	1	1 034	0,1
Total foreigners	373 141		694 937	
Total Abidjan				

Migration was not distributed evenly across all social categories, and the mix differs by area. According to the 1975 and 1988 national censuses (RGP) and the 1978-1979 EPR, and consistent with historical and ethnographic evidence, Burkinabè migrated mainly to rural areas relative to domestic and other international migrants. Burkinabè migrants were mainly young men, with men in their mid to late twenties and older tending to migrate with their wives — ethnographic evidence shows that Burkinabè men, once they had saved up money working in Côte-d'Ivoire, would return to their native villages to marry, bringing back their brides to the city if their jobs allowed them to support their families there (Cordell Gregory and Piché 1996, Deniel 1969, Skinner 1965). Other international migrants were also mainly men, with the notable exception of

[8] Adapted from Zanou and Aka 1994:10. This data should be taken to indicate trends only. The number of foreigners is always strongly underestimated as many prefer to declare themselves Ivoirian; in addition, many have double nationality. The number of French and Lebanese is clearly too low in the 1988 census, and Liberians currently make up a significant group since the civil war there, which broke out after the 1988 census, brought an enormous amount of refugees to the city. Nigerians, Ghanaians, Liberians and now Sierra Leoneans make up a substantial anglophone minority in the city, as can be judged by the ubiquity of anglophone businesses and churches. In addition to the French and Lebanese, visible minorities in the city include South-east Asians (largely Cambodian and Vietnamese refugees) and a growing number of South Asians, Koreans (mainly missionaries with Korean protestant churches) and Chinese.

Ghanaians, who were mainly young women (Dureau 1985:317-318). This is consistent with ethnographic accounts that in matrilineal patrilocal Akan ethnic groups (which include Ghanaians and, in Côte-d'Ivoire, Baoulé), young women migrated easily to the city and frequently married out of their ethnic group. It appears that this was an accepted strategy for "opting out" of an unwanted marriage (see chapter 3 and Chauveau 1987, Étienne 1979, Domergues 1986 notes that prostitutes identified by the colonial venereal disease services were mainly Baoulé and Agni women). This appears to confirm earlier ethnographic observations, as well as the common contemporary association of prostitution with Ghanaian "tou-tous" (for "two-pence," see Rouch and Bernus 1957).

After World War Two and up to the 1970s, international migrants to Abidjan came largely from foreign cities, although these may have been only transit points. Domestic migrants were more likely to have come from towns than from rural zones, but came from all over the country, with distance not being a factor (Dureau 1985:297)[9]. Migration to Abidjan is believed to have been largely for work reasons. Migrants who could not find work in provincial cities moved on to Abidjan, actually swelling unemployment figures there to a level higher than provincial cities (ibid). Migration for schooling is largely domestic, and accounts for fully one-third of domestic migrations and was mainly to provincial centers, where schooling was cheaper[10]. The following map showing the origin of students in a Bingerville school illustrates the distances over which educational migration extended:

[9] This is contrary to earlier studies in Ghana and the Zambian copperbelt (Caldwell 1969), which showed distance to be a factor in migration. Distance was probably attenuated as a factor because of (i) Côte-d'Ivoire's relatively good transportation infrastructure and (ii) the relative centralization of commercial and government infrastructure in Abidjan

[10] Dureau's exhaustive analysis of the 1978-1979 EPR offers the most detailed picture: see pp 297-350; he discusses the relative contribution of job-seeking and schooling to Abidjan's growth on pp 331-332. This analysis is taken up in more synthetic terms in Chaléard and Dubresson 1989, particularly pp 281-284. These observations are consistent with the subsequent 1988 census, although there appears to have been an increase in educational migration to the capital (Zanou and Aka 1994:17-18).

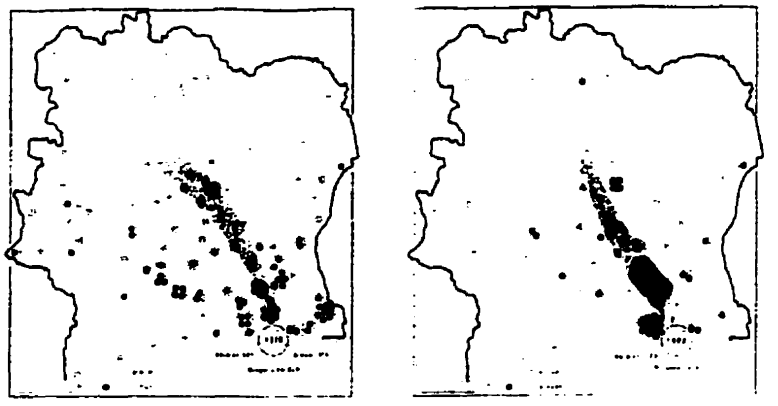

Figure 4.15 • Geographic study of educational migration to and from Bingerville, the former colonial capital that succeeded Bassam and preceded Abidjan. On the left, points of origin of students in Bingerville. On the right, where Bingerville parents send their children to school. From Berron 1980:146

The city's demographic makeup shifted through the sixties, as the ratio of women to men increased. This was for two reasons. As men found work, they brought their families to the city. Families tended to bring young girls with them to help around the house, and left boys at home, where they could work in the fields. In addition, young women came to the city for schooling. The increase in women of childbearing age contributed to an overall increase in fertility, although this was tempered gradually over time by the effect of education: women who pursued studies beyond a primary education had decreased fertility, although it is unclear whether this was because of delayed age of marriage or increased use of contraceptives (Antoine 1981, 1988).

Postcolonial mobility

The demographic data clearly indicate that migration is a fundamental fact of the Ivoirian postcolony. Migration is the standard demographic term to describe movement of individuals. However, the term mobility is preferred here for two reasons. First it distinguishes between the coerced migrations of the colonial era (those associated with forced labour, conscription and head taxes) from movements undertaken under less coercive conditions: for seeking work or to trade for example[11]. Migration was initially driven by brute force, and then

[11] This is not to imply that mobility is free from broader forces — capitalism — which can be construed to be coercive.

economic considerations, as seen in chapter 2. Evidence from this ethnographic record of the sixties and seventies indicates that other factors come increasingly into play. People move to gain access to education and health care[12], but also as a strategy for reconfiguring social relations. Oppressive families, desire for recognition and social status, wanting to explore new options are all cited as reasons for moving.

Secondly 'migration' implies a rare event both in the lifetime of individuals and in a population as a whole; however, its frequency and embeddedness in the everyday life of Abidjanais makes it phenomenologically more accurate to speak of mobility. Demographic surveys consistently indicate that roughly one third of the population 'migrates' yearly — migration thus affects the majority of the population over the span of a few years, and is likely to happen very often to individuals. The ethnographic literature from Côte-d'Ivoire confirms the demographic data, and shows that migration is a cyclical process, which recurs regularly in the lives of Ivoirians and Abidjanais (Chaléard and Dubresson 1989, Étienne 1979).

Observers agree that mobility increased, starting in the mid fifties and picking up through the sixties and seventies. The "bright lights" of the big city promised economic opportunity and freedom from constraint, certainly a significant "pull." In the sixties, mass education and television contributed to the allure of the city. The increasing dissemination of popular cultural forms — notably music — extolling the excitements, pleasures and dangers of the urban *ambience* doubtlessly also played a role (White 1998). Schools and television were introduced simultaneously throughout the country. In fact, a shortage of teachers led to a widespread program of using television to teach schoolchildren (Desalmand 1986). Expansion of schooling was, understandably, concentrated at the primary level. A burst of school construction, largely financed by local communities, began in the years of limited self-rule in the late fifties and continued through Independence until 1963-1964. Incentives to register children in school — including free school uniforms and shoes in some districts —

[12] contrary to the commonly-held assumption of European planners that people move *to* Abidjan to access western medical care, I found that the majority of health-driven migration is *from* the city to the village, in order to access less expensive medical care and avoid expensive burial fees.

massively swelled primary school enrolments during this period, as shown in the following table:

Table 4.2 • Number of secondary schoolteachers in Côte-d'Ivoire

	Ivoirian	%	Expatriates (French)	%
1962-1963	10	1.4	506 (410)	98
1972-1973	341	13.9	2108 (1445)	86.1
1982-1983	3248	59.2	2237 (1205)	40.8

Proteau 1997

However the postcolonial state very quickly adopted a selective educational policy, restricting entry into middle and secondary school. These hurdles created bottlenecks (*goulots d'étranglement*) of students who were forced to repeat years. Those that continued their education went to schools in urban areas, creating a migration incentive that registered strongly on demographic data. With the advent of the economic crisis in the mid eighties, diplomas no longer translated into modern jobs, school fees became mandatory throughout the public schooling system and it was increasingly common for schoolteachers to make up salary cuts with incentives from parents. As a result, schooling became far more expensive at the same time as real incomes and the market value of diplomas fell. The result was twofold. First, an entire generation that had been socialised in the state school system and had developed modernist expectations of the future were unable to continue their studies — they were "deschooled."[13] Only 1% of primary school attenders would complete the *Baccalaureate*, the diploma recognising completion of secondary school (Cohen 1974), creating a large class of the educationally disinherited: the *déscolarisés*. "Deschooling" — or lack of access to higher levels of education — disproportionately affected rural dwellers, girls, and the poorer segments of society. This further intensified migration to the city, where *déscolarisés* headed in droves, believing they could make better use of their literacy skills. These flows partially inverted during the economic crisis of the eighties. Job seekers returned to the village to work in agriculture, and decreased educational access (subsequent to the structural readjustment plans) reconfigured migratory patterns, as youths sought out cheaper educational opportunities outside of

[13] The term 'drop-outs' is not used, because the circumstances leading to children to abandon school are different than in Western countries. The term '*déscolarisés*' is widely used to refer to this phenomenon by Ivoirians, the popular press, and social scientists.

Abidjan or as far away as Burkina Faso. The implications of this will be explored in the next chapter.

Conclusion

Migration to large cities is a universal fact of life across developing countries, an indicator of integration into the global capitalist economy. In postcolonial Côte-d'Ivoire mobility remained largely a product of economic motivations, as it had in colonial times. In contrast to the colonial period, however, State modernisation policies created a budding network of institutions and economic opportunities that played an increasing role in individuals' migratory trajectories. The "miraculous" economic growth of the sixties and seventies during a period of political stability enabled state investment in social and economic infrastructure on an enormous scale. The scope of these investments, as we saw in the case of the housing sector, is visible in the city's modern infrastructure: the port, freeways, hospitals, and universities. It also heralded a social modernity, characterised by a significant 'modern' — or salaried — labour sector, changing family relations, the promise of mass education and access to social services. Although these changes never materialised, largely because the economic boom barely lasted two decades, they had created expectations. For instance, the impact of state education policy on mobility extended beyond those who moved in order to attend school to influence those who moved because they had attended school. As in the case of the housing sector, even though the State's intervention was only partial, it nonetheless configured the entire social landscape of the generations that entered into it.

This modernity, although an arrested one, transformed the social environment. Under colonialism, ethnicity defined the terms of social reproduction. Ethnicity determined the role one was to have in the colonial economy, and the reproductive strategies available through kinship; it was both a material constraint and a resource for imagining the future. With the arrested modernity of the postcolonial era, the individual became the new substrate on which the material future was imagined and enacted. In other words, individuality replaced ethnicity as the hinge between persons, the state, and (re)production. This had implications both in the response to the economic crisis through the emergence of a dynamic

informal economy, therapeutic patterns of resort, and sexuality. These will be the subjects of the next two chapters.

In the colonial period options — and possible futures — were few, limited to manual labour (on plantations or the railway), trade, or colonial service. Furthermore, how one would imagine one's strategy for material survival — as a labourer or a clerk — was conditioned by ethnic identity, as attributed by the colonial state (chapters 2 and 3). The postcolonial state's modernisation program emphasised schooling, urban planning, and the development of all the apparatuses of a modern nation-state. As will be shown in the next chapter, the programme fell short of its objectives with the economic crisis triggered by a dramatic collapse in commodity prices in 1979. This event created a gap between the social modernity that was the unfulfilled goal of the postcolonial state's modernisation programme and the cultural modernity it reflected. With the economic crisis, the state's "promissory notes (Wittrock 2000)" — notably the benefits of education and modern health care — became worthless as institutions were hollowed out by structural adjustment. However, a cultural modernity fostered by socio-economic modernisation had already translated into the Ivoirian imaginary. Ivoirians continued to imagine their fate and construct their lives around individual choices, whether these concerned schooling, economic strategies or romantic relationships. This individualisation persisted even though the premises under which it had been engaged — a "modern" economy — no longer existed. The gap between the expectations Ivoirians had of modernity and everyday life was experienced as an uneven, or incomplete, modernity. It is in this gap that social change was most strongly felt and acted upon. This will be the subject of the next chapter.

Chapter 5
Economy, modernist tactics and social change in the First Republic

Introduction

This chapter concerns social change in Côte-d'Ivoire's First Republic, which was born with independence from France in 1960 and ended with the dissolution of the Republic's institutions by General Robert Guei after the Christmas Eve coup of 1999. The processes of individualisation set in motion by the modernisation programme of the First Republic discussed in chapter 4 trace their genealogy back to the elements of colonial modernity discussed in chapters 2 and 3: the plantation economy, ethnicity, mobility, and urban space. This chapter will examine how the economic crisis of the 1980s and 1990s compromised the modernisation program. It will also show how the remnants of this modernisation articulated with economic tactics individuals used to weather the crisis. These sedimented over time into a modernist urban culture with consequences for both sexuality and therapeutic resort that, it is argued in chapters 6 and 7, explain the scope of the city's HIV epidemic.

The second part of this chpater focuses on the economic tactics Abidjanais used to weather the crisis. These tactics are the common thread runs across the informal economy, diverse youth cultures, religious movements, and therapeutic industries, that together texture everyday life in Abidjan. These tactics allow individuals to negotiate a complex and differentiated social reality characterised by an ever-present oscillation between the country and city, between the "traditional" and the "modern," and between brief periods of economic exuberance and the anxious monotony of poverty. That is, these tactics negotiated social change. Modernist tactics, the negotiation of social relations, and the enactment of social change, resulted in the emergence of a sexual modernity (Chapter 6) and a therapeutic modernism (Chapter 7) that explain the timing and extent of the AIDS epidemic in Abidjan.

The colonial and postcolonial context of social change

The years of the First Republic[1] accelerated the social change that had been ushered in by the colonial era. The production of space, political economy, and colonial mobilities defined early social change, which was mediated by new cultural forms such as ethnic identity, voluntary associations and religious movements (Chapters 2 and 3). While the postcolonial state's modernisation project aimed to enact a social modernity,it was nonetheless firmly rooted in colonial engagements with the world economy. These colonial residues — urban space, political economy and cultures of mobility — and postcolonial ambitions defined the terms of engagement with the post war global order.

The First Republic's modernisation programme, of which urban planning was the flagship, ground to a halt with the economic crisis of the 1980s that was triggered by a collapse in export commodity prices. This collapse was symptomatic of the broader global economic reconfiguration that was the result of the oil crisis of the 1970s. This reconfiguration marked a break in the post-war economic system that

[1] The First Republic was ushered in with Independence in 1961 and ended with the military coup that overthrew President Bédié on Christmas eve 1999 and installed General Robert Guéi. With popular ratification of a new constitution in mid-2000 the Second Republic came into existence. The current head of state is Laurent Gbagbo, who came to power after a popular uprising to contest General Guéi's attempt to steal the presidential elections from Gbagbo. Although Gbagbo won fairly, his main opponent, former IMF Deputy Director Alassane Ouattara, was excluded from running on nationality grounds.

had consolidated around a consensus on the role of the state as the focal point for articulating Fordist production, labour markets, and the accumulation of capital. The oil crisis precipitated the shift to post-Fordist forms of production and so-called flexible accumulation. This transition has been widely interpreted by social theorists as marking the transition from "modernity" to "post-modernity." These analysts have addressed this transition, and the ensuing "condition of postmodernity," as symptomatic of a new configuration — and expansion — of global capitalism (Harvey 1994). Marxist analysts have largely focussed on the cultural and social ramifications of "late" or "disorganised" capitalism in Western countries .

In Côte-d'Ivoire's peripheral economy, the transition to "post-modernism" or "late capitalist" global economic formations marked the painful end of the "miracle" of economic growth. For Ivoirians it was as much a crisis of modernisation as a crisis of modernity itself. I have chosen to use the analytic categories of modernity and modernism to discuss these social changes because, as we shall see, this is the prism through which Ivoirians themselves understood and enacted social change. Awareness of the global nature of the processes that affect everyday life in Côte-d'Ivoire is heightened by the economy's dependence on export prices. This awareness dates to colonial times, when higher prices for coffee and cocoa were paid to French rather than to native planters, a major political grievance at the time.

Partial modernisation and uneven modernity

The "boom-and-bust" nature of modernisation shaped both contemporary Ivoirian society in general and Ivoirian cultural modernity in particular. The result was what can be called an uneven, incomplete, or patchwork modernity. This is not to imply a singular, normative conception of modernity of which Ivoirian reality was a derivative; rather, it reflects commentary Ivoirians themselves make on a modernity that they perceive to be lacking. As a rule, modernity refers to the complex socio-economic and cultural reality that came about in the Western world with the rise of the nation state. The secularisation and rationalisation of everyday life and the increasing application of scientific and statistical knowledge was accompanied by the emergence of concepts of individual autonomy and

individualisation. As Berman (1988) has noted, modernity is a paradoxical phenomenon, comprising both the experience of as well as the unprecedented potential for mass destruction and the commodification of everyday life. In this vein, Foucault has underlined the dark side of modernity in its ability to constrain and shape experience through the use of disciplinary technologies. For my purposes here, rather than flush out a better definition of "modernity" I wish to underline its globalising form while paying attention to its contingent and local configurations.

The "new affiliations, identities and...institutional realities" characteristic of social modernity entail "promissory notes" (Wittrock 2000:37). This metaphor is particularly apt for understanding the way Ivoirians have understood modernity. Where Ivoirian modernity most often falls short is in its ability to deliver a promised future. As shown in the previous chapter, the fact that modernisation, whether in state policies, urban planning or social relations, was a structuring feature of everyday life in the period after Independence, played a large part in generating expectations of modernity. These expectations — that one's children would get a job consonant with the schooling one has paid for, the promise of a return on an investment, the hope that an illness would be treated — were eminently reasonable in the light of official discourses and institutional practices and the experiences of colonial rule (see chapter 3 concerning *évolués* and the creation of an African intellectual class that became a nationalist élite). As the economic crisis of the 1980s deepened, modernity, both as the explicit goal of the state's broad modernisation policy, and as a social project, was compromised.

However, the state's modernist practices, as we saw in the previous chapter, had conjugated socio-economic *modernisation* — development of modern institutions for managing the economy and educating the population — with a certain social *modernism*. By this, I refer to its "ostentatious"[2] preference for the aesthetic styles of modernism, the self-conscious opting for the new and those things that signified a break from the traditional. The striking urban modernity of Abidjan —

[2] The word is used in World Bank 1996, but is often encountered in English language journalistic, travel and academic writing on Abidjan and is more frequent still in descriptions of Yammoussoukro, President Houphouët's natal village. Houphouët transformed Yammoussoukro into the national capital and built a full-scale replica of St Peter's Basilica using imported Italian marble and craftsmen.

as contrasted with Dakar — is emblematic of this modernism. As we shall see, modernism — in styles of dress or dance, in the aesthetics of social relations — was a robust legacy of modernisation.

Modernist tactics

By favouring mass schooling and a legible social order — of which the Cartesian grids of the modernist urban plans are the best example — the colonial state set in motion processes of individualisation that went on to intensify social change in the forty years following Independence in 1961 (chapter 4). While urban plans and housing furnish perhaps the most dramatic evidence of a clearly modernist preference for straight lines and visible order that signalled a break with the ramshackle of the "traditional village," the way in which individuals chose to fashion the social relations around them and react to misfortunes that beset them can also be characterised as *modernist*. That is, they reflected a conscious attempt to improvise and configure new social relations with the expectation that these could help to deliver the benefits that the modern world promised. Modernism in social relations and aesthetic styles persisted even as modernisation — as social projects and government policy — waned. This modernism, in other words, was the sign of a practical and ideological commitment to the possibility of progress.

Three elements characterise modernist tactics. These elements share an aesthetic dimension, first of all in their reliance on a "social dexterity," or art of social relations. Part of this dexterity involves the capacity to "read" other individuals, and the social networks in which they circulate, effectively. This can be contrasted to forms of social relations mediated through kinship, where the position of interlocutors is clearly legible. The term "tactics" draws on De Certeau's distinction between "strategies," which occur in an organised social field where agency is readily discernable, and "tactics," which occur in a heterogeneous social field where agency cannot be expressed in terms of clearly defined goals and instrumentalities. Thus the distinction between modernist social relations and kinship-derived social relations is analogous to the distinction between "tactics" and "strategies" (De Certeau 1990 pp59-61). Secondly, the importance of practices of self-fashioning — tactics for developing individuality — can be contrasted with forms of social relations where collective processes fashion

individuals, as in the example of initiation ceremonies carried out in village settings. Finally, the third element involves individualised forms of economic improvisation and planning for the future, rather than the ethnically-aligned trades of the colonial period that did not articulate a vision of the future predicated on a relationship with secular institutions such as the state, financial institutions, education establishments, and so on.

The term modernist — rather than modern — focuses attention on the aesthetic, or fashioned, quality of these social tactics, and forces us to view individualisation in a more ethnographic light[3]. In so doing, I do not wish to imply that these tactics are somehow frivolous, or irrational. Rather, I wish to draw attention to how cultural choices and local "inventions of tradition"[4] — and of the modern — inform the manner in which Africans seek to act upon social reality around them. The term militates against the tendency to attribute to "westernisation" phenomena that do not conform to postcolonial ideas of the "traditional." Often, the manner in which "westernisation" is used is reminiscent of older, colonial idioms that dismissed native agency as only so much colonial mimicry (Magubane 1971). In this usage, "westernisation" thus designates a derivative modernity. In contrast, "modernism" can serve as a lens to capture the agentive fullness of the broad range of tactics and practices — some reflexive, others less so — by which Africans seek to engage with the contemporary world. Postcolonial modernisms demonstrate a cultural continuity with the voluntary associations, prophetic movements, and ethnic tactics described in chapter 3. The vigour, creativity, and enthusiasm with which Africans engaged in this social project throughout the continent was aptly referred to as *la passion moderniste* by the French sociologist of Africa, Georges Balandier (White 1998).

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[3] That is, rather than proceeding from social structure to everyday experience, this notion forces us to consider how individuals react to broader social formations.

[4] The term is from Hobsbawm and Ranger 1983; the danger that this notion reintroduces the notion of an "authentic" tradition — or modernity — has been commented upon. As should be clear from the thrust of my argument in this dissertation, the notion of "authentic" tradition or modernity is empirically unsustainable.

The economic crisis, its causes and the response

The economic history of Côte-d'Ivoire explains in large part the growing gap between the expectations that Ivoirians developed of modernity and the opportunities and challenges of everyday life. The years after Independence coupled economic growth with massive state investments in public works, education, and housing. This modernisation was accompanied by broad social changes that were embraced by many urban Africans. The manner in which they engaged with these social changes, with reconfiguration of social relations, is what I have termed modernist. Under the assault of the economic crisis of the 1980s, modernisation crumbled and the state was no longer able to deliver on the "promissory notes" its programme implied.

The Ivoirian crisis first became evident in late 1978, with the collapse of coffee and cocoa prices on the global market. The Ivoirian economy was singularly dependent on coffee and cocoa, crops that had been introduced under colonial rule. Intensification of coffee and cocoa cultures was the central element of the postcolonial state's strategy for acquiring the foreign reserves required to pay for the international inputs essential to its modernisation programme. The impact of the drop in export prices spiralled into a full-blown crisis that year as a second petrol shock sent oil prices skyrocketing, increased the value of the US dollar. Interest rates skyrocketed, increasing the cost of servicing the Ivoirian debt that the modernisation programme had incurred during the 1960s and 1970s. This significantly deteriorated the balance of trade for a country that was heavily dependent on exports to keep its modern economy functional. The Ivoirian government's sluggish response to the crisis, which at the time was thought by decision-makers as merely a temporary circumstance of events, only exacerbated the impact of its worsening trade situation. When drought affected coffee and cocoa crops, falling agricultural outputs together with falling export prices and rising import prices brought down the heavily indebted economy like a house of cards. In 1980 the Ivoirian government contracted its first structural adjustment loan from the World Bank.

Though the causes of the crisis were subject to intense debate, most observers agreed on the complexity of the interplay of situational and structural factors. Situational analyses focus on circumstances external to the Ivoirian economy

(world commodity prices, interest rates and so on) that led to the "crisis." This was the view of the Ivoirian government, that saw itself as the victim of a chain of unfortunate circumstances. Structuralists, on the other hand, drew attention to structural weaknesses in the Ivoirian model: "fundamental contradictions in the prevalent mode of accumulation, with enormous transfers from the agricultural sector to the foreign dominated industrial sector" made it inevitable that external shocks would swamp the system (Fauré 1989:71). Indeed, the "Ivoirian model" was used as a case study in dependency theory by Marxist political economists. These studies argued that a small indigenous postcolonial planter class and an expatriate metropolitan (in this case largely French) bourgeoisie conspired to run an export-oriented economy. As a result, capital investment in the colony was kept to the minimum needed to extract resources with profits returning to the colonial centre. The lack of further investment in the development of a local industrial base constituted a model of structurally "blocked" development (Amin 1967).

The structuralist analysis eventually proved largely correct (Campbell 1997), although in hindsight the structural problem extended far beyond the Ivoirian model to the organisation of the global economic system. The realisation that the problem ran deep was slow in coming. A fleeting economic upswing occurred in 1985, as favourable climatic conditions resulted in bumper coffee and cocoa crops. The cyclical nature of the cocoa crop and the vicissitudes of international capital markets, as well as the palliative effect of structural adjustment loans, masked the structural elements of the crisis. As a result, awareness that the real crisis was the eclipse of the economic "miracle," was gradual, a dawning realisation that crept up throughout the 1980s. Structural adjustment policies were implemented as a condition of the structural adjustment loans the Ivoirian government contracted with the World Bank at three-year intervals starting in 1980. These loans were conditional on a broad range of structural reforms that transformed the Ivoirian state's modernisation programme. These "conditionalities" played a major role in how Ivoirian society reacted to the recession.

In the implementation of these conditions, Côte-d'Ivoire was a "model pupil" (Duruflé 1988:118), exceeding the World Bank's targets. The 1980 loan mandated a reduction in public investments from 25% to 16.5% of GDP over a

three year period; in 1983 the Bank noted approvingly that the volume of public investment was down to 12% of GDP. This decrease translated into a massive 40% cut in public investments in real terms; by 1985, two years later, these cuts had increased to 70% (Kanbur 1990:11, Duruflé 1988:121). A second loan contracted in 1983, was more adventurous in its prescriptions, directing the diversification of the plantation economy into palm oil, rubber, and coconut, and cautiously promoting the development of sugar, soybean and irrigated rice production. This diversification met with only partial economic success. The loan also stipulated reforms in state housing policy, most notably, rent increases through 1985 to reflect market values as well as major reductions in housing benefits for civil servants (Kanbur 1990:11-14). Meanwhile the government continued to obtain expensive credit — in effect recycling the country's debt — in the global equity markets based on overly optimistic predictions. This worsened the drain on the state's finances when expected economic growth did not materialise (Duruflé 1988:120-124). Côte-d'Ivoire defaulted on its loan payments for the first time in 1987.

Despite being a model pupil, structural adjustment was a qualified failure in Côte-d'Ivoire. Commenting on "the disproportion between the results obtained in terms of debt relief, and the costs, measured in terms of deflation, divestment, and decreases in social services," Duruflé, an economist with the French Ministry of Cooperation, attributed the failure of structural adjustment to the limits of the mode of political and economic accumulation that the Ivoirian miracle had characterised (Duruflé 1988:141). With the benefit of twelve additional years of hindsight, it is the structural adjustment policies themselves that are now singled out as the causes of these failures. This is explicitly acknowledged, even by the World Bank, and is attested to by an increased emphasis on "poverty eradication" in the Bank's lending.

The economic impact of the crisis

While certain effects were felt immediately, others took longer to register in the social fabric. Decreased public inputs shrank the formal economy by 30% as the state reduced salaries and froze hiring. The impact of this cannot be exaggerated, because the state was by far the country's largest formal employer and paid high

salaries, partially because of the preponderance of French bureaucrats and technical advisers who stayed on after Independence and "artificially" inflated salaries. Earning good incomes in the modern sector, civil servants redistributed income through extended kinship networks, both in the city and the country[5]. As a result of structural adjustment, urban per capita income decreased by 45% between 1978 and 1985 (Duruflé 1988; see Table 5.1 below). As a result, the economy entered a deflationary spiral, short-circuiting the strategy of increasing government revenue through stimulating economic growth by liberalising the economic sector.

Table 5.1 • Progression of poverty in Côte-d'Ivoire, as measured by economic indices[6]

	1959	1970	1979	1985	1988	1993	1995
GNP per capita*			396	314	281	234	226
Private consumption per capita*			225	189	187	148	129
Incidence of poverty				*11.1*	*17.8*	*32.3*	*36.8*
*Intensity of poverty***				*2.9*	*4.5*	*9.0*	*10.4*
*Severity of poverty***				*1.3*	*1.7*	*3.4*	*3.2*
Gini coefficient***	0.46	0.53	0.61	0.39	0.35	0.37	0.35
Income share of lowest quintile	6.6%	3.9%	2.1%	5.4%	7.3%	7.1%	7.5%

* Figures are expressed in thousands of CFAs, at constant 1987 prices.
** The intensity of poverty index "measures the percentage shortfall in aggregate consumption of the poor below the poverty line. Thus in 1995, the intensity of poverty index was 0.84, implying that to raise the consumption level of each poor individual exactly up to the poverty line of CFA 144,800 would require a sum equivalent to 8.4% of the poverty line multiplied by the total population. In theory, a perfectly targeted subsidy to the poor of this amount could enable all minimum consumption needs to be met. This is equivalent to 5-6% of GDP, a very substantial gap...the severity index, is a weighted index of poverty giving the greatest weight to those who are poorest" (World Bank 1996:9-10).
*** The "gini coefficient" measures the degree of economic inequality in a society by measuring the gap between actual distribution of incomes and an ideal income distribution.

A somewhat conflicting picture emerges from the data concerning the overall impact of structural readjustment and the economic crisis. Macroeconomic indicators suggest that income disparities grew during the boom years, only to be compressed with the crisis. However, "all three indices of poverty — incidence, intensity and severity — have increased consistently over the 1985-1995 period of the crisis. Collectively, the indices point to a rapidly building crisis" (World Bank 1996:8-9; see table 5.1). In other words, the boom years benefited the wealthy more than the poor. With the recession, the wealthy lost proportionately

[5] It is worth underscoring here that the number of dependents is proportional to income rather than actual kin relations.
[6] World Bank 1996:9

more income, but for those less well-off, relatively smaller losses plunged many into a spiral of poverty. Another paradox is that although macroeconomic indicators of social inequality (the Gini coefficients and their share of national GDP of the poorest quintile, noted in Table 5.1 above) *improved* during the crisis, on the other hand social scientists writing about various facets of life in Abidjan detected a *worsening* inequality (Vidal 1990, Le Pape, Vidal and Yapi-Diahou 1991, Vidal 1997).

Three reasons explained the apparent contradiction. First, *perceptions* of inequality changed. As the crisis dashed expectations, those who were worse-off, realising that the chance their situation might improve were nonexistent, grew more sensitive to inequality. Second, responses to the crisis were heterogeneous. The crisis "separated the wheat from the chaff," as some managed to improvise tactics for preserving income while others did not. Anecdotal and ethnographic data confirmed World Bank economists' findings that a "lucky few," even amongst the poor, were able to preserve their assets (Grotaaert 1995). As a result, differential outcomes occurred *within* social worlds, as neighbours and friends were only too aware. Third, in addition to these experiential reasons for the heightened sensitivity to social inequality during the crisis, the legacy of early postcolonial state housing policies, and the explosion of the "informal" economy during the crisis years, refracted the impact of the crisis. This generated inequalities within the "subaltern" social class that had previously defined itself relative to a monolithic and ostentatious nationalist élite. The "little people" became "paupers" (Vidal 1990). The mechanisms that refracted inequality within social groups, and that also allowed the "lucky few" to weather the economic crisis more successfully, are the subject of the rest of this chapter.

Figure 5.1 • Adjamé, 2000.

Impact on housing policy

Once the government privatised the public housing firms, allowing market forces to operate freely in the previously subsidised modern housing market, a significant margin of the "middle classes" who had aspired to modern housing, were no longer able to afford market rates and were forced into the informal housing sector. Municipal services to what were previously considered shantytowns initially improved as the social capital of its inhabitants improved with the influx of new, less marginalised, residents. The state ceased to bulldoze illegal neighbourhoods in 1989. This has been taken as an indication of the new political clout of the residents of these informal neighbourhoods[7], although it is more likely that pressure from the World Bank, worried about the risks of social instability, brought about this change in policy (Dembele 1997, Yapi-Diahou et al 1991). This situation constituted a tacit recognition that the goals of the urban plans of the 1960s and 1970s — modern housing for a largely middle class urban population — had been abandoned.

Less remarked upon has been the shift in housing policy that may have actually deepened social inequality within the middle class, although this was not its intent. Those who had purchased subsidised housing were largely able to preserve their economic status, compensating for revenue shortfalls by renting out property. Those that had not were economically vulnerable to rising rents as state

[7] Interestingly, destruction of informal neighbourhoods began again after 1995 once the economy improved, with the destruction of the shantytown of "Washington."

subsidies were removed, and as job and salary cuts came about, these individuals found themselves impoverished (Vidal 1997). In other words, the already fragile middle class fragmented, those with property being well positioned to take advantage of subsequent economic growth because of the capital they were able to preserve, and those who were not property owners were no longer shielded from market rental rates by state housing subsidies. As a result, these people found themselves more exposed to poverty. Thus, the economic crisis revealed a paradoxical effect of the state's housing policy. While constituting a subsidy to the better off, it also encouraged modernist economic tactics — accumulating capital in the form of real estate — that paid off in times of recession. Structural adjustment-mandated ends to subsidies were meant to level the playing field for the poor, but in times of economic recession, liberalisation of the housing market contributed to swell their ranks.

The educational crisis

As mentioned previously, with structural adjustment, investments in educational establishments were drastically curtailed as state funding for the educational sector was scaled back. Enrolments declined because the combination of school fees and the loss of faith in the value of educational diplomas meant that parents were less willing to invest in schooling. Girls were disproportionately affected. This effectively "deschooled" a generation of youth, who went to primary school but had little access to schooling beyond the 6th grade. This change is reflected in the decline of gross educational rates (the proportion of the population of school age that has ever been to school):

Table 5.2 • Gross educational rates[8]

1985-86	1988-89	1989-90	1990-91	1991-92	1992-93
74.5%	72.8%	71.8%	69.1%	67.7%	66%

While most children attend primary school, *goulots d'étranglement* — bottlenecks — in sixth and tenth grades mean that many children are not able to continue beyond this stage. Statistics collected by the Ministry of Education indicate that the number of students passing into 6th grade decreased gradually from 45% at

[8] Proteau 1997:639

Independence, and stabilised at roughly 15% at the end of the 1970s. The decline in passages into 6th grade were a reflection of hugely increased cohort sizes in the period just after Independence; however, as cohorts were already shrinking by the mid 1960s entry rates into 6th grade remained stable threafter. Entry into 10th grade was directly impacted by the crisis: admissions fell precipitously from over 50% just before the crisis to roughly 10% by 1994.

The social consequences were enormous, particularly as these partially schooled children had acquired basic literacy skills in French along with a desire to integrate into the modern economy. As a result, new generations grew up feeling cheated of the promise of modernity, particularly because they believe that education will give access to a job and financial security.

What happened to these generations of deschooled youth? As the economic crisis deepened into a recession, many families expected children to pull their weight by contributing financially to the preparation of family meals. Those that did not were expected to eat elsewhere. As many as a third of children in Côte-d'Ivoire are "*confié*," or placed with relatives (Étienne 1979). This is usually because urban relatives are considered wealthier and therefore more able to support the schooling of rural children. The crisis in schooling partially reversed the flow of child placement in favour of rural areas, as children that were too much of a burden — because they got into trouble on the street or were unable to support themselves — were often sent up-country, either to live with relatives or to return to their parents in rural areas. This is reflected in demographic data that show a slowing rate of migration to Abidjan largely because of population transfers back to rural areas (Charléard and Dubresson 1989). Among those who stayed in the city, many joined the informal economy, some as apprentices or to learn manual trades. Some went into "*affaires*," or " business." This usage corresponds to the popular term "hustling," as Abidjanais call, "what you've gotta go out and do every day to survive your life." This usage that does not imply prostitution. This involves engaging in commerce of goods obtained by unorthodox means or in confidence schemes. Others took up the *petit metiers* (odd jobs) that the city is famous for (Touré 1985). As Le Pape (1986:112) notes, hustling implied a set of skills: the art of relations, social dexterity, or a capital of aptitudes and social resources. Access to primary school modernised youth by giving them literacy skills and generating expectations of a place in society. While some returned to

the village, the majority of these youth swelled the ranks of those in the urban, para-modern economy, with outcomes that will be explored below.

Figure 5.2 • Tire patcher.

The effects of change in the education system extended further than to those who were excluded from pursuing their studies, however. Prior to the crisis, university studies were not only free, but students who passed the *baccalauréat* received bursaries and numerous other benefits. This reflected the Ivoirian state's desire to invest in creating an élite class, in the manner of the French *grandes écoles* system, that could take over the mantle of the state's institutions from French bureaucrats trained in France.

As salary freezes and increasing workloads decreased the spending power of teachers, selection for entry into higher classes became less dependent on academic merit alone. *Le couloir* (connections), bribes, and even sexual favours emerged as tactics that could guarantee academic promotion (Le Pape 1986, Ginoux-Pouyaud 1996). This was in addition to the financial burden imposed by school fees, a mechanism of cost recovery that structural adjustment imposed in

Côte-d'Ivoire, and indeed throughout the developing world. As a result, educational success became increasingly dependent on students' ability to mobilise social, financial, and occasionally even sexual capital. The latter was humorously referred to as "MST" (*moyennes sexuellement transmis*, or sexually transmitted marks; Proteau 1997:651), the acronym commonly used to refer to sexually transmitted diseases (*maladies sexuellement transmises*). Youth developed a plethora of tactics for raising money and connections from relatives. Flowery letters to senior brothers were perhaps most typical of this genre (Le Pape 1986).

These skills unwittingly promoted by the school system, became part of the art of "hustling" (Le Pape 1986). As students contracted moral debts to kin, the risk of academic failure, and the ensuing compromise of their social relations that they had mobilised to pay school fees, raised the stakes of academic performance. Paradoxically, individualisation, the hallmark of socio-economic modernisation, led to an intensification of dependence and accountability to the "traditional" kinship networks that had to be utilised in order to guarantee entry into the school system — a phenomenon that has been referred to as "arrested individualisation." Strikingly, the accumulation of debts to kin was experienced as increasing exposure to witchcraft accusations and attacks. Witchcraft accusations and fears became idioms through which the oppressiveness of increased dependence on kinship relations were expressed (Marie 1997b).

The "informal" economy

Between 1980 and 1985 there was an "explosion" in the "informal" economy (Haeringer 1988). Abidjan began to look like other African cities: the sterile appearance of its throughways receded as sidewalks and roadways grew crowded with ambulatory vendors and impromptu businesses of every kind. It seemed as though the crisis had unleashed a previously unsuspected entrepreneurial zest and creative spirit. *Maquis*, the "native" watering-holes previously cloistered in courtyards in the colonial tradition (Chapter 2), spilled out onto sidewalks, and older corner boutiques diversified. Much like the way many multinational corporations mutated into holding groups for diversified businesses, some boutiques utilised their brand image in neighbourhoods to bring together wildly different business lines, offering customers the chance to purchase basic

necessities, but also make phone calls and photocopies, get their hair braided, have letters typed, and so on. With time, these boutiques returned to focus on their "core" business when competition from newer entrepreneurs crowded them out of these business lines.

For modernisation theorists, the informal economy represents a transitional stage from subsistence-oriented, traditional economic forms to more mature, capitalist modes of accumulation. As a result, informal economies were little studied until the 1970s. However, their growing economic dynamism belied the predictions of the modernisation theorists, and heralded a spate of studies throughout the developing world. In Abidjan, these studies identified a bewildering array of trades, practices, and *savoirs-faire*. Indeed, it seems that no area of everyday life was not in effect, commodified by the informal economy. The trades exercised within the informal economy extended from barbers, tailors, carpenters, gardeners, hair braiders, and car-washers, to car-parkers , card-plastifiers, water resellers, light-bulb repairers, foot-washers, soothsayers, group psychotherapists, nail-clippers, cell-phone re-programmers and walking bankers... Of course, this is in addition to merchants selling every kind of good imaginable.

Figure 5.3 • Contortionist child in Treichville (photo Erica Burnham)

Two crucial observations emerged from these studies of the informal economy. The first was the striking modernism of this sector. While some of these trades might be considered artisanal, the majority were highly individualised, both in the way skills were deployed, and in the imagination with which market niches were carved out. This observation can still be made today. For instance, in the huge Adjamé market, reputed the largest in West Africa, there is a significant bookstall section (like markets all over the world, each section of the market is highly specialised in a particular good — nails, pineapples, plastic tubing, and so on). The most successful booksellers are young boys with little more than elementary schooling who will, if one picks out a copy of a book by Lévi-Strauss, immediately seek out and present books by other structuralists. This is simply because they have memorised the interests of previous clients who picked up a book by Lévi-Strauss, much in the manner that Amazon.com suggests books to its browsers.

Figure 5.4 • Performing tradition (photo by Erica Burnham)

The second, related, observation about the informal economy is that economic success was highly dependent on the ability to maintain and "read" social networks. In an economy where liquidity is in short supply, economic success involves knowing to whom it is possible to extend credit, for how much and for how long. Merchants who extend too much credit will be unable to recover debts and stand to lose money; those who extend too little credit will not generate sufficient turnover for their business to be viable. In addition to skilful manipulation of credit, merchants rely on social networks for three other business fundamentals. Social networks furnish the intelligence to determine the market value of goods and fix prices that are competitive, but that can still generate profit margins. Networks also decrease transaction costs by allowing sellers to have a "direct line" to producers or importers; conversely, social networks translate into distribution networks for wholesalers. Finally, networks are essential to accumulating savings; indeed, the "thrift clubs" of the colonial period (chapter 3) have their contemporary counterpart in the form of *tontines* and ambulatory bankers. As a result, the market of the informal economy is deeply socially embedded even though it is highly individualised.

Urban cultures and modernist tactics

With the advent of the crisis the horizons of possibility, which had seemed so vast at the time of independence, seemed increasingly constrained. For youth who could no longer continue their schooling, or students who could no longer expect a job upon graduation, the deception was particularly cruel. The inability to establish an economically stable situation for oneself in Ivoirian society, as was the case for many of these young people, condemned them to a kind of perpetual social adolescence. Unable or become economically self-sufficient — and hence to marry — they could not be recognised as true adults in either "traditional" or "modern" terms. Youth excluded from the modern economy grew increasingly disenchanted and embittered as the years of crisis dragged on.

The political significance of these modernist expectations was foreshadowed by events a decade *before* the crisis. On 30 September 1969 mass demonstrations held by "unemployed young men" led to mass arrests, the first warning sign that, even in good times, the "economic miracle" had generated a tide of rising expectations that were difficult to meet. The movement was dismissed by the authorities as an ethnic and xenophobic protest[9], although eventually a quiet series of protracted negotiations and piecemeal reforms were undertaken (Cohen 1972). Coming at a time of high foreign investment and high economic growth, the repression with which the demonstrations were met (1,489 were arrested and held for 3 months at the Akouedo military camp east of Abidjan, where they were badly treated and frequently beaten) was the first evidence that the Ivoirian authorities were prepared to maintain political stability, even at the cost of violating human rights and ethnicising political conflict. Political stability — or, more accurately, the *perception* of political stability — was seen as critical to the success of the foreign-investment dominated economic model.

Population growth, which swelled the ranks of the young, only exacerbated the problem when the crisis commenced in 1979. By then, it had been made clear that in Houphouët's one-party state, open political dissidence was frowned upon,

[9] Some of the young men voiced the concern that "foreigners" were taking jobs away from them

and some of the resulting disenchantment was channelled into more or less underground political activities that would eventually lead to the advent of multi-party politics in 1989. Much of this disaffection also found expression in a variety of urban cultural forms — such as *zouglou* dance[10] and music — that were later recuperated by the state as emblematic of Ivoirian national culture. That it did so demonstrates the relative tolerance that existed under Houphouët, for in other African countries antagonistic forms of political expression had to be even more coded.

Figure 5.5 • Urban protesters in 2000.

The result was the convergence of a strong undercurrent of protest in the urban popular culture of Abidjan. Protest found its expression in a myriad cultural forms — mainly popular music and dance — that signalled the emergence of an urban culture centred on the social reality of Abidjan. This popular culture was wedded to the growth of the informal economy that characterised the popular response to the economic crisis. The lingua franca of this urban culture is *nouchi*, an Abidjanais dialect. *Nouchi* combines French, English, and mainly Dioula words within a syntax poor in prepositions and articles that its speakers describe as "African." Recalling the multi-ethnic nature of Abidjan and the extraordinary proportion of migrants, French was, and still is, the dominant common language.

[10] Zouglou dance involves a series of motion where the dancer's body language asks "why?", pleading to the right, then to the left, and finally upwards because only God knows the answer (Bahi n.d.)

Dioula, a language of traders spoken in markets, comes a distant second. My informants recall that *nouchi*, although no one called it that at the time, was already widely spoken in the 1970s. Their awareness of its distinctiveness came from school, where it was forbidden and they were at times punished when they spoke it. For largely sociological reasons, *nouchi* does not appear to have yet acquired the status of a creolised language, as few children learn it at home[11].

Figure 5.6 • Treichville children (photo by Erica Burnham)

Nouchi has become the linguistic vehicle for the youth culture of Abidjan. The expansion of *le parler d'Abidjan* is linked to both the crisis and the response to it — the development of the informal economy — in multiple ways. Partial schooling and high literacy rates originally reinforced French as the *lingua franca* in this multiethnic city — no African language achieving national status in the manner of Mooré in Burkina Faso, Swahili in Tanzania or Wolof in Sénégal. This was for both demographic and political reasons, no ethnic group being dominant in the city, and French being the language of modernisation. In addition, the demographic preponderance of youth — as in many developing countries, over half the population is below 18 years of age — helps to disseminate the linguistic innovations of youth culture.

[11] By now, many *nouchi* speakers have had children but given their economically precarious status their children are usually raised by relatives who speak other languages.

The ethnic and linguistic heterogeneity of the city extends into its neighbourhoods. Although in parts of the city certain groups may predominate, the mobility of urban dwellers across the different sections of the city precludes the development of linguistic enclaves. Consequently, it is amongst the city's most mobile elements that an investigation of the urban culture of the city may begin. It is in these mobile elements that the new lingua franca of the city — *nouchi* — emerges and, by extension, the cultural vernacular of urban life.

Moving, calling, collecting

Gbakas are an example of the patchwork modernity that characterises social life in the city. *Gbaka*, a *nouchi* word whose origins are unknown, is the word for Abidjan's private 20-seat minibuses[12]. *Gbakas* have existed in the city since the late colonial period. In 1960, the city's urban transit corporation (the *Société des Transports Abidjanais*, or *SOTRA*) was formed to respond to the transportation needs of a growing population in a growing urban area. Initially, *SOTRA* had a small rolling stock of Renault buses, but the private *gbakas* were nevertheless tolerated. By 1974, however, the *SOTRA* was well equipped with second hand buses from French cities and *gbakas*, deemed a nuisance because of the recklessness of their drivers, were banned from the city core. With structural adjustment, however, *SOTRA* had difficulty recovering its costs and keeping its ageing fleet on the road. Breakdowns were legion, and delays became commonplace. The company was unable to respond to the transportation needs generated by the explosive growth of the communes of Abobo and Yopougon (now estimated to have between one and two million inhabitants each), both of which are over 10 km from the central Plateau district. As a result, these sprawling cities are mainly served today by *gbakas*, a policy that was encouraged by the World Bank's emphasis on liberalisation of the transportation sector in the late 1980s.

In addition to a driver, a ticket-collector or conductor is required on a *gbaka*. The profession of *gbaka* fare-collector — the term used is *apprenti* — is one that has largely been taken up by deschooled youth. These youths, as young as 15, but in their late teens and early twenties on average, are a fixture of everyday life in the

[12] English-speaking Africanists may be more familiar with the term *matatu*, which is used in Nairobi.

city. Most noticeable as they dangle out of open doors, sucking their teeth loudly and rhythmically shouting out destinations, these youth are *nouchi*-speakers *par excellence*. The staccato of destination calls interspersed with comments on seating availability is *nouchi*'s metronome and rhyme, the beat of city life. *Nouchi's* cultural versatility is best appreciated as *apprentis* slither through a crowded *gbaka*, bills curled between their fingers, collecting fares and negotiating conflicts with and between passengers. Their habitus and speech is emblematic of the urban culture of the city. Interviews I conducted with *apprentis* led me to estimate that the number of youths that engage in this occupation is significant, perhaps in the tens of thousands. (Many work part time, and move in and out of this line of work, making estimates difficult.) Reputed to be "*petits loubards*" or rogues, many of these youth actually live with their families and contribute economically to the household.

Belying their reputation, *apprentis* actually earn a significant income, averaging 6000CFA per day (roughly $15), which is three times the average income for unskilled work. (*Apprentis* get to keep whatever fares they collect after the *gbaka* has left its terminus — hence the economic motivation that explains their assiduity in beckoning, cajoling and seducing passengers onto moving vehicles). The work is of course difficult and dangerous — agility, coordination, and stamina must be accompanied by social skills. *Apprentis* have to know how to "go with the punches" with their drivers, whose personalities are described in terms of the types of music that they prefer to accompany their driving — plaintive Ivoirian reggae, soothing Afro-zouk, frenetic Bacheke as Zairian soukouss is called locally, or soulful Malian music. Surprisingly, the elaborate décors and decals sprouting religious iconography (*Allah est grand, Jésus est mon maître*), ethical slogans (*la beauté d'un garcon, c'est le travail*), and political figures (Houphouët of course, but also Thomas Sankara and Jerry Rawlings[13]), are not considered expressions of driver personality, but rather more like a jerry-rigged in-flight entertainment system, gathered over time to attract passengers and keep them amused. *Apprentis* also must know how to "speak properly" with passengers and have a repertoire of techniques for scanning the crowds that pullulate along the

[13] Sankara and Rawlings were radical Army captains who led coups to power in Upper Volta and Ghana respectively in the early 1990s. Sankara renamed his country Burkina Faso and instituted a socialist régime widely admired for its adherence to principles before his overthrow in 1996.

roadside in order to detect potential passengers, get their attention, and entice them on board.

Some apprentis save their incomes, investing it in bank accounts at local credit unions that were set up by the Québec *Fédération des caisses populaires Desjardins*[14]. With these savings, some of these youth dream of paying the fees necessary for getting a driving licence and, with a driver's income, eventually saving up enough to buy their own *gbaka*. These youths translate a modernist faith in credit unions, the stability of the state, and the value of money into pragmatic, everyday economic tactics. They have so far been the "lucky few" — very few indeed — for whom *apprenti*-ship can translate into social stability. Some have succeeded but most spend their money on beer and women in the *maquis* of the *rue Princesse*, the blaring hotspot in Central Yopougon, where they can dance to *zouglou* until dawn.

Bodybuilding

[14] Banking fees make other banks inaccessible other than to the wealthy. Caisses populaires, like the Grameen Banks in Bangladesh, have spread throughout West Africa and have made "micro-credit" a reality in many poor communities.

Figure 5.7 • Bodybuilding competition.

"Real" *loubards* — roughnecks — also form part of the social landscape of the city in general, and the sprawling popular township of Yopougon in particular. The stocky young men who led opposition to Houphouët in the late 1980s and early 1990s, and before that in the 1969 "sans travail" demonstrations, were said to be Bété. The Bété are a diverse group of "tribes" in the south-west of the country who were fused into one ethnic group by the French colonial administration. Their reputation as quarrelsome likely originated in colonial times, when French policy encouraged "*allogène*" Baoulé planters to develop plantations in Bété country. The Baoulé, migrants with a kinship structure that had been adapted to the plantation mode of production, consolidated their plantations and were more successful than the Bété. Their smaller plantations demonstrated a more rigid lineage-based mode of production (Hecht 1986). The Bété also had competition from the west, because Kru from Liberia were encouraged to develop plantations on their land. These diffuse rivalries and struggles over land crystallised as a Bété rivalry to the

Baoulé who, once Houphouët was made President, became the politically dominant ethnic group (Dozon 1985). Labelling dissenters as Bété came easily[15].

Figure 5.8 • Urban protest 2000. Traditional Seroufo hunters marching in support of the Rally of the Republic Party.

The term *loubard*, because of its connotations of criminality and public disorder, is not one that is sought out. There is a popular perception that many *loubards* have "recycled" themselves in the private security industry. Certainly, the sight of intimidating, generously muscled young men patrolling in front of Abidjan's chic shops and nightclubs is a common one. This niche of the informal economy is not considered glamorous. It is not a "modern" office job, but nonetheless, it is a better option than being unemployed. As a result, a subculture of bodybuilding is tied into this professional category of the informal economy. Free weights, barbell racks and bench presses, ingeniously engineered from recycled auto parts, are used by youths in impromptu gyms. Special diets are consumed, with the hope that a well-developed physique will allow the consumers to appear sufficiently strong to get a job as a bouncer at a nightclub. The pay is average for unskilled labour — 50,000 to 60,000 CFA, or $100, monthly — and is just enough to pay rent, food, medicines and the occasional night out. However being a bouncer

[15] The current President of the Second Republic, historian Laurent Gbagbo, was for many years the lone opposition figure to Houphouët and is himself Bété.

offers the opportunity for tips, especially from patrons who feel they might not otherwise gain entry.

Like others in the informal economy, these *loubards* are "deschooled" — but literate, and this has had important implications. The crisis of the 1980s ushered in an era of "insecurity" in the 1990s, as armed crime became rampant, and Abidjan developed a reputation for danger rivalled only by Lagos, Nigeria. The stark realities of cheek-to-jowl inequality had always been there, but with growing crime the wealthy became increasingly nervous about the potential for danger. As a result, private security has become a booming industry. Initially, most firms were French owned, but enterprising *vigils* — as security guards are known — set up and expanded their own firms. Many of these entrepreneurs drew on skills and contacts acquired during military or police service. The high literacy of the work force meant that these firms were able to professionalise easily.

The growth of marginalised immigrant communities in the vast suburban developments ringing Paris has been paralleled by a growth in petty — and occasionally violent — crime and youth gangs modelled on American "gangsta" inner city culture. Consequently, the market for private security is a rapidly growing one in Metropolitan France, one that cannot easily be met with French labour alone. As a result, over 170 Ivoirian private security firms have branches in the greater Paris area. These security firms offer expertise in security, but also a ready supply of cheaply paid, largely illegal, African labour[16]. In addition to being cheap, literate, and muscled labour, *Abidjanais* security guards have the added advantage of knowing urban street culture, and therefore of being better able to "reason" with their "*black et beur*" (Black and Arab) French "brothers." The reality is, of course, not so simple. Local gangs do not look on eager security agents kindly, particularly when their zeal has resulted in local gang members' being hauled off to the local *Commissariat*. For the undocumented Ivoirian security guards, engeance is a common, and occasionally deadly, consequence of this line of work. But for these young Ivoirian men still in Abidjan, the chance to go to France is all they dream of. Leaving Abidjan for Paris is not a simple affair, however. Visas and papers can always be arranged, but require the right contacts who can assist with visa form preparations, supply the required documents, and

[16] "*Envoyé special*," France-2 Télévision, rebroadcast on TV5 28 March 2001.

coach potential immigrants in how to pass interviews with French officials. For those with a modicum of schooling and the ability to fashion their bodies into an intimidating physique, immigration to France represents the dream of a better future.

Hustling

For those whose bodies or minds do not direct them into guarding or manual labour, *les affaires* — "hustling" — may be an option. Some who go into this line of work have obtained their *baccalaureat*, or have even been able to attend university; others have been "deschooled" because they have not been "serious" in their studies and have not obtained the grades to finish high school. Considered "intellectuals" by other youths because of their schooling, they were not considered apt for manual work, or for hawking goods on the side of the road.

Those that are "good-lookin' fast-talkin'" often get involved in a seemingly endless array of get-rich-quick scams. These all involve earning a wealthy person's trust, usually by offering that person a chance to earn money easily with a minimum investment, while at the same time appearing naïve and unaware of the actual potential of the scheme. The wealthy person — "because they are greedy and they think other black people are stupid while they are smart because they are rich" — is duped into making the initial investment and then strung along until the trickster vanishes with the money. Methods for gaining the investor's confidence include bank accounts, dummy corporations, "black money" (suitcases of US dollars soaked in black ink that can be removed with a special solvent), and a slew of business plans. Certain nationalities are associated with particular expertises: Nigerians with bank accounts and credit cards, Cameroonians with corporations, and so on. The schemes are convincing because the inked dollar bills are real, as are the bank statements and government authorisations that have themselves been obtained through connections.

Others go into religion. As one informant explained to me, "it depends on which environment you've been in. Those that go to Church and are smart figure out how it works...you know, most of their preaching is based on give, give, give...here you have a bunch of poor people turning to God to improve their

situation and all you've got to do is say give 2 cents here or 3 cents there and you've got a thousand of them in your Church and you figure it out, you've got 4,000 dollars at the end of the day." The potential of small contributions to multiply into considerable sums became most visible with advent of the Brazilian Pentecostal "Universal Church of the Kingdoms of God" in Abidjan. The Church bought up all the local neighbourhood cinemas and converted them into halls of worship. The cinemas were packed day and night as back-to-back sermons succeeded each other, accompanied by exhortations for contributions. This would inevitably reach a frenzy with worshippers throwing in fistfuls of bills — sums that had to be carted out in, it was rumoured, trucks.

What exactly characterised youths who "made it" in these urban, African capitalist practices? Intelligence, being articulate and being "good-looking" were prerequisites. Being "good-looking" does not refer to physical attributes, but rather to looking the part: trustworthy, upright, honest. In addition to being "good-looking," also one has to be "open to other cultures," and have experienced many different *milieux*. This is something that comes "with travelling" — hence, the preponderance of non-Ivoirians who are successful. Hustling money or donations to religion was explained as largely a product of circumstances, of a path settled into after the trials-and-errors of trying to survive in a succession of African cities.

Recent commentary on "millennial capitalism" has linked the salvational character of capitalism at this neo-liberal turn of the century with the proliferation of Neo-Pentecostalisms like the Universal Church of the Kingdom of God, as well as a "resurgence" in occult beliefs and practices. The "thickening hegemony" of neo-liberalism, it is argued, is refracted in cultural forms that both partake in the magical dimensions of capitalism — getting rich quick — and, through the proliferation of witch-hunts and zombie-panics, articulate suspicions that flexible capitalism and post-Fordist accumulation are nothing more than hyper-virulent forms of mutated capitalism (John and Jean Comaroff 2000). While this argument draws attention to the counter-hegemonic potential of popular discourse, it does not account for the purely pragmatic dimension of engaging in witch-hunts, evangelical preaching, and impromptu venture capitalism on the streets of African cities. Indeed, it tends to exoticise African capitalisms, rather than calling attention to the decidedly cultural dimensions of the western categories of

"investor confidence," the "new economy," and even economics *tout court*. Arguably, there is not much that is new about capitalism, which has always followed an inexorable logic of globalisation and colonisation of the life-world (Hirst and Thompson 1996); nor about African vampire rumours that were already in the 1930s a common metaphor for the experience of colonisation (Luise White 1993a, 1993b, 1995a, 1995b).

Conclusion: modernist tactics and social relations

The economic crisis of the 1980s is refracted through the prism of urban protest, youth culture, and the informal economy. The common thread running through these social phenomena are, I have argued, modernist tactics. These tactics persisted even in the absence of a modernity that was "good-enough" to meet the expectations that the modernisation program had generated.

Individualising economic strategies, that is, tactics (*apprentis* saving up money in the local credit union), the art of reading and manipulating social relations (knowing whom to extend credit to, or whose confidence might be earned and how), and the transformation of one's self (through religion, or through body-building), are hallmarks of modernist tactics for negotiating the complex and differentiated social reality of the city. While these activities mark a shift from social relations articulated around kinship relations, ethnically differentiated economic tactics, and collectively enacted forms of marking personhood, they do not occur in isolation of these older modes of engagement. Indeed, kinship, ethnicity, and collective rituals — funerals, births, weddings — are the background against which modernist tactics set out individual trajectories.

These tactics I have discussed are a sampling of the social pragmatics that characterise everyday life in the city. They do not necessarily articulate resistance to dominant values, although at times they do, as we saw in the *sans-travail* demonstrations and the politicisation of Bété ethnicity. Nor do they express a dominant ideology, although at times they do that too, as in the case of the "lucky few" whose success, even in the face of structural adjustment, shows that market liberalisation can improve the lot of some. These tactics are at times used with explicit goals in mind — getting to France, purchasing a vehicle — or at times

just as a way to pass time, or assuage the suffering of poverty. Modernist tactics, the pragmatics of urban life, both express and constitute subjectivity. As we have seen, the form these take is often dictated by the negotiation of urban and social space. The environments one crosses are as important as are innate attributes or the household one was raised in.

Opposing tradition to modernity is a shorthand for understanding social change that obscures more than it reveals. Individualisation is not a product of social modernisation, but the historical by-product of colonial practices of government that lay the groundwork for ethnic strategies of identification (see chapters 2 and 3). Postcolonial modernisation layered over these colonial practices of identity-attribution substituting the individual for the ethnic groups as the locus of identity (chapter 4). While the economic crisis of the 1980s aborted modernisation as a social project, modernist forms of social relations evolved according to their own cultural logic, and in the process made available new tactics for assuring material reproduction. As has been shown in the discussion of the informal economy.

Social change was not a result of modernisation *tout court*, but of modernist engagements with the material realities of social life that resulted in an entangled patchwork of recombined "modern" and "traditional" forms. Expressions of gender and sexuality are one of the areas where these social changes are most evident, resulting in what I have called a sexual modernity: this will be the subject of the next chapter.

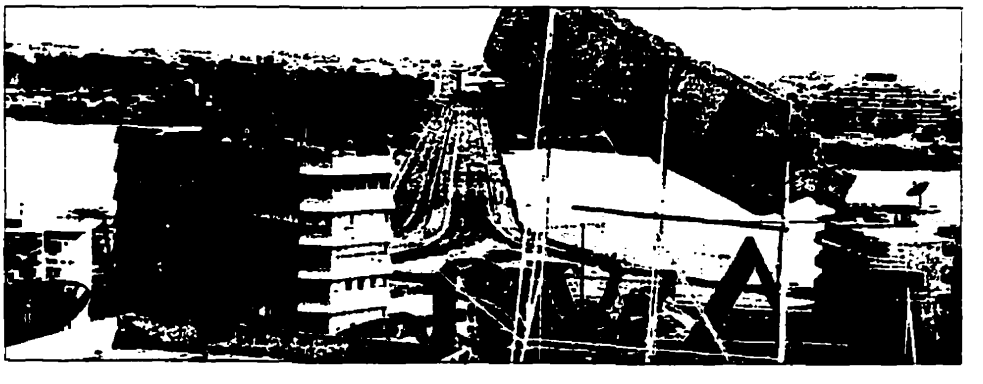

Figure 5.9 • Pont Houphouët

Chapter 6
Sexual modernity in the First Republic

Introduction

Migration and prostitution are commonly believed to explain why Abidjan is the epicentre of the AIDS epidemic in West Africa. This has been based on inferences from epidemiological studies that showed AIDS emerging as the leading cause of death in men in the late 1980s, high rates of HIV infection in prostitutes, and a steady decline in the male to female sex ratio of cases from 4.8:1 in 1900 to 1.9:1 in 1993. Yet these conditions were also present in other coastal cities in West Africa. Intensity of migration and sexual behaviour certainly played a role, but attention must be paid to more subtle social and biological factors to explain why seroprevalence rates in Abidjan are currently *double* those in other large cities throughout West Africa (UNAIDS 2000). This chapter argues that understanding qualitative — rather than quantitative — changes in behaviour is of utmost importance to an analysis of the epidemiology of the disease.

The proportions that the epidemic has reached in Abidjan should be understood in the context of both the sexual and therapeutic culture of the city. The latter will be addressed in the following chapter.

This chapter turns to the first piece of the puzzle, that of sexual behaviour. The social changes effected by colonialism, urbanisation, and modernisation had their corollary in changes in sexuality — what I call the advent of a *sexual modernity*. This chapter will define and explore the nature of this sexual modernity, a term that includes sexual behaviour, but also captures the representations, strategies and tactics that inform behaviour. Furthermore, I will argue here that this was a development that came early to Abidjan relative to other parts of West Africa.

The processes of modernisation that accelerated in the postcolonial period shifted sexuality from the domain of ethnic strategies of reproduction (as in the case of Baoulé demographic growth, discussed in chapter 3) to that of individualisation. Specifically, social modernism (chapter 5) made sexuality available as a strategy for "self-fashioning," and for furthering individual needs, desires and pleasures. As a result, sexual relations became increasingly permeable to modern — economic — forms of rationality. In a context of increasing social inequality, initially between and then extending within social worlds and social networks (chapter 5), this is likely to have had an important impact from the point of view of HIV transmission, as this chapter will demonstrate.

This argument runs counter to the oft-stated hypothesis that urbanisation "freed" sexuality from the cultural restraints exerted in more "traditional," village settings, implying that there was an increase in the quantity and/or variety of sexual activity. I have found no data to support this claim. Indeed, ethnographic accounts of traditional initiation ceremonies indicate that this may be a period of considerable sexual liberty (Holas 1961). The contrast between a "traditional," and controlled, sexuality with a "modern," and presumably promiscuous sexuality is often invoked to explain why the HIV epidemic spread with urbanisation and modernisation. However, like many culturalist explanations for the epidemic, this hypothesis is advanced with little in the way of data to support it.

Behaviourist models quantify sexual behaviour and make a case for "determinants" of that behaviour by correlating it with social factors. Behaviourist models have been favoured over earlier epidemiological categories that defined those "at risk" for HIV infection in terms of unchanging identities. However these are static, rather than dynamic, models. That is, they detect trends in seroprevalence rates in social groups *after* infections have happened. This

epidemiological research is hampered by its reliance on *post-facto* categories — "prostitutes," "truck drivers," "homosexuals" — that, as ample social science research has demonstrated, are elaborated in an absence of data grounded in the empirical reality of everyday life, and reflect prevailing stereotypes. Understanding how HIV spreads, and the potential magnitude of epidemics, requires an understanding of how sexual networks are constituted, as well as how individuals constitute themselves as sexual beings within social networks and broader cultural constructs.

This can be shown by a brief consideration of the emerging epidemiology of HIV in America. As was shown in Chapter 1, the breadth of sexual networks explains whether epidemics stay cloistered in specific groups or not. That HIV was largely a disease of gay men through the 1980s does not so much testify to the promiscuity of gay men — although clearly promiscuity played a role in establishing a beachhead from which the disease could pose a serious threat to the rest of the homosexual population — as to the fact that most homosexual men only slept with other homosexual men. This is what epidemiologists refer to as "assortment:" whether transmission occurs between "like" and "non-like," that is, within or across social groups, although how these groups are to be defined is most often not specified. For instance, that the epidemic was largely constrained to gay men in its first decade indicates that sexual behaviour in this group was assortive. In anthropological terms, it also indicates that sexual identity was relatively homogenous and robust across this group.

This is not always the case, as can be seen in recent developments in the AIDS epidemic in America. There, disease incidence is increasing in groups not thought to be "at risk" either in terms of "identity" or "behaviour," notably rural women in the American south. New evidence suggests that many of the men who have sex with men in American minority groups are bisexual, and do not see themselves as "gay." This is being use to explain increasing incidence of HIV in groups not traditionally thought to be at risk. Significantly, the impact of class, gender, incarceration rates, and lack of access to health care — what can be glossed as social exclusion — on HIV transmission in America has been largely ignored. The evolving epidemiology of HIV in America, as well as in Africa, calls for theoretical tools that would allow an understanding of the relationship between these socio-

economic variables, sexuality, and the biology and epidemiology of HIV transmission.

In this chapter I advance the notion of a sexual modernity to (1) embed sexual behaviour within a local context (2) understand sexuality as a strategy for negotiating social change, rather than being determined by cultural or economic factors in a fixed way. Thus, differing local configurations of cultural and economic factors can lead to different strategies, different sexual networks, and distinctly different epidemics.

In epidemiological terms, sexual modernity in Abidjan led to "dis-assortive" sexual behaviour. That is, sex between "like" and "non-like" became more common, in effect extending the range of sexual networks. The ethnographic evidence presented in this chapter will show how these sexual networks are positioned within broader economies of needs and desires, demonstrating the importance of an ethnographic approach to complement epidemiological research.

If changes of sexual behaviour occur within broader processes of socio-economic modernisation, why then, speak of *a* sexual modernity rather than the "modernisation of sexuality?" This is to dissent from the more common view that "modern sexuality" represents the "liberation" of an essential, or "natural," sexuality from repressive sociocultural forces. This point has been well argued by Foucault (1984a), who has shown that sexuality should be seen as an "incitement to discourse," as the discursive deployment of a constellation of concerns around the body that serves to shape and give expression to sexual behaviour. In later volumes of his History of Sexuality, Foucault (1984b, 1984c), implied that sexuality was but one of a variety of regimes for fashioning the subject through bodily and spiritual exercises. Thus, meditation, dietetics, bodybuilding, or sexuality can be considered as "technologies of the self," strategies that individuals use to influence their position in a perceived social order.

Drawing on Foucault, I use the term sexual modernity to refer to two linked phenomena. The first is the individualisation of sexual imagination and behaviour, a phenomena which does not imply a normative vision of "modern" sexuality. Sexuality was one of the modernist strategies (chapter 5) that became

available to individuals in the negotiation of social change in Côte d'Ivoire. A second, and linked, phenomenon is the emergence of sex, sexual behaviour and desire as an object of discourse, that is, as something that is spoken, written about, and performed. The emergence of a discourse on sexuality indexes it as a problematic area of individual experience and, as a result, as an area that requires working through by those individuals. Discourse — whether self-help, rumours, advice columns- suggests a range of strategies available to individuals for working through these problematic areas.

In addition, the *contingency* of the modern — as discussed in chapters 2, 3, and 4 — makes it difficult to sustain claims about *a* "modern sexuality." Whether one considers Ivoirian modernity as "incomplete" — unable to deliver on the promises that Ivoirians felt they were made in the postcolonial period — or "alternative," it is characterised by the persistence, and even the proliferation, of traditional/modern hybrids in social and economic life. This underscores the point that simple traditional/modern dichotomies are unlikely to be helpful in considerations of sexuality. That these dichotomies have persisted is in large part because they are a shorthand for describing social change. The binary categories of traditional and modern help to make sense of social change and master the proliferation of meanings that social change engenders. The argument counters simplifications that have been all too common in discussions of the HIV epidemic on the African continent, particularly in the way "culture" has been used to explain differences in epidemics.

The growing economic — and sexual — independence of women in Abidjan through the 1970s was the subject of a number of ethnographic accounts (Vidal 1991). "Free women" and "mistresses," a lightning-rod for discussion, became a subject of vigorous debate, and crystallised male anxieties over their own economic vulnerability. The proliferation of discourse on "modern" female sexuality paralleled the increased education of women and a decline in fertility in educated women. This represents the "demographic transition" that would be expected with social modernisation. This ethnographic, cultural and demographic data will be discussed below as evidence of the emergence of a sexual modernity in Abidjan in the late 1960s. As an "ultramodern" and "westernised" city, it is not surprising that these concerns emerged in Abidjan earlier than elsewhere. But *was* Abidjan truly a hub of sexual modernity?

This chapter draws on historical and ethnographic evidence to argue that the social organisation of homosexual behaviour in Abidjan is further evidence of a sexual modernity in Abidjan that consolidated through the 1970s. I must underline what this argument is not: I am not advancing that the presence of a precocious "gay" community in Abidjan explains the extent of the AIDS epidemic there. Rather, my argument is that social change, and its corollary, sexual modernity, results in changes in sexual *networks* (who has sex with whom), rather than sexual *behaviour* (how often sex occurs and which sexual acts are involved)[1].

Modern women, anxious men and dangerous mistresses

The first signs of a sexual modernity in Abidjan were the emergence of smartly dressed young women that appeared to invade the city. That something had changed is supported by looking at the historical record: up until the fifties, the population of Abidjan, like other African cities, was still largely made up of young male migrants from the countryside. Fetchingly dressed young women were scorned and treated as prostitutes. Rounded up by the police, they were often forced to undergo speculum exams and vaginal disinfectants were administered (Vidal 1979).

Gradually the city "sweetened," as elegant women, clad in western and African fashions, new hairstyles, and seductive behaviour became part of everyday life. This did not pass unnoticed, neither by the men it "inflamed," nor by chroniclers of everyday life in the city, as can be seen in the hit songs, the gossip, and advice columns of Abidjan's dailies during this period. The papers — and the public that read them — were preoccupied with the new sexual liberalisation, the brazenness of lycéennes (high school girls), the mix of seduction, money, and power. "Where else could Ministers be seen in their Mercedes outside schoolyards?" they asked (Vidal 1977).

Was the widespread *Abidjanais* practice of keeping a mistress — or two — the modernisation of polygamy, and hence acceptable in the name of African values?

[1] A similar argument is advanced by Rotello (1998) to explain the location of the AIDS epidemic among gay men in America.

Or was it a threat to the African family? Why were such "ultramodern" women so desirable to men? Mistresses were assumed to divide their time between several lovers, so the issue of exploitation did not come up very often (Vidal 1979). Most resented was the economic barrier to having mistresses — if one was a "big man", with a car and a government job, there were no obstacles. But for the "little men," labourers and lowly clerks, things were not so easy. The discourse on mistresses crystallised male anxieties about the rapid pace of social change that, in the context of the economic crisis, threatened the promise of modernisation that had ushered in the First Republic, and which had been the implicit terms under which many male heads of household had engaged in urban life (Vidal 1991).

Housewives modernised too. In the seventies, they started businesses out of the family home to supplement the income their husbands earned in the "modern" sector. Behind the "modernisation" of housework lay a "traditional" reason. Husbands stuck to traditional ideas of family responsibility, only handing over enough money to keep food on the table and pay school expenses for children. The rest, wives assumed, went for the upkeep of mistresses. Conscious of the tenuousness of their hold over their husbands, wives developed their own strategies for achieving economic independence. Like the *maquis*-owners and purveyors of palm wine in the colonial period, women were behind the emergence of an informal economy (Vidal 1977, 1991).

When the crisis hit, their husbands lost their "real" jobs, and the balance of power in the household shifted. Women were economically empowered, relative to their husbands, as shown by data that female-headed households weathered the recession better than male-headed households (Kanbur 1991). As a result, women demanded a greater say in things. The debate was acrimonious, an escalation of a veritable "war of the sexes" that had already begun in the years of the "miracle." At that time, wives had already begun to demand accountability from husbands, and men beat their wives (Vidal 1977). Recession accelerated the trend. Serial surveys indicated that the proportion of women who were active in the workforce increased from 29% to 49% between 1979 — the year the crisis hit — and 1992 (Vidal 1997:662).

The pioneering work of Le Pape and Vidal has called attention to the discourse around sexuality that proliferated in Abidjan in the 1970s and 1980s. This

proliferation was not constrained to the press — which in the context of rapidly rising literacy rates was widely read and commented upon, often in public — but also came up in everyday conversation, gossip and rumour; in hit songs, dances, *photo-romans* and other forms of popular culture; and even in the embodied practices of dress, posture and *démarche* (Vidal 1977, 1979). That romantic love was the principal subject of popular culture is certainly not unique to Abidjan. For instance, seduction and the incitement to physical pleasures such as dance was — and still is — the focus of Soukouss, the African *musica franca* that originated in Kinshasa (White 1998). But, as Vidal (1991) has pointed out, popular culture articulated a highly specific set of concerns that crystallised the social issues deriving from the economic changes happening in the city, including as the changing status of women.

Unfortunately, questions of sexuality and desire were largely off-limits to ethnographers through the 1970s and 1980s, other than under the rubric of kinship. Research and writing about sex was considered by many in the Africanist milieu to be "slightly crazy" (Vidal, personal communication). Yet, frank talk about sex was not hard to come by in Abidjan in the 1970s and 1980s. Writing in 1984, Le Pape and Vidal report conversations with African women about African sexual practices that were compared by their interlocutors to "European ways." These were deemed superior because "European men know their way around," and were willing to engage in varied practices. As a result, sex with them was assumed to be more varied than repetitive demonstrations of male prowess[2]. None of these stories were based on first-hand experience, however, demonstrating the power of representations of the other to afford a vehicle for the social critique of gender relations. These African women, although resigned to the fact, deplored the frequent absence of pleasure that sex with African men apparently entailed (Le Pape and Vidal 1984).

The anthropological literature on kinship indicates that, in the traditional societies that were the object of ethnographic scrutiny, the question of who may have sex with whom is expressed in terms of social relations rather on the basis of than physical beauty and sexual desire (Radcliffe-Brown and Forde 1950). However,

[2] See also Sévédé-Bardem 1997, who reports a similar discourse from interviews with young men in Ouagadougou in the 1990s, also in the context of structural adjustment.

some ethnographic accounts suggest that sexual license and perhaps even experimentation was allowed within recognised boundaries, such as the period following initiation of young men and girls; this literature does not allow us to state with precision how desire was expressed in these liminal periods (Holas 1961). Along with the evidence presented in chapter 3 concerning the reproductive strategies of urbanised Baoulé women, this indicates that "traditional" sexuality was clearly not homogenous. Nonetheless, ethnographic and cultural studies in Abidjan indicate that in the post-colonial period sexuality became increasingly linked to individual desire, certainly at the discursive level — whether for pleasure, beauty, power or wealth. Demographic data that demonstrates a decrease in fertility during this period has been attributed to a corresponding decrease in reproductive sex, as measured in delayed marriage, although not necessarily a decrease in sexual practices at large. However, little data on infertility during the period exists, a significant lacuna, since epidemics of sexually transmitted infections translate into decreased fertility even though sexual activity may not decrease (Antoine and Herry 1981, Antoine 1988).

To what extent can it be claimed that this sexual modernity was an early development in Abidjan, relative to other cities West Africa? Abidjan was certainly an "engine of growth," the "economic lung" of the region, the focus of a vast migratory system that linked it to the Ivoirian hinterland, Burkina Faso, Mali, and even Sénégal. But was it a hub of sexual modernity as well? Anecdotal evidence for this is strong — Abidjan's liberal ways were known throughout the region. Given the relative paucity of the historical record, ethnographic data must be used to verify this hypothesis.

Whether or not homosexuality is a universal phenomenon, the notion that same-sex desire organises individual life-trajectories and social relations is a distinctly modern one and, therefore, can be taken as emblematic of sexual modernity. The discourse on homosexuality in Abidjan will be considered below. Its emergence will be chronicled in three social spaces: the *milieu* of drag-queens and dandys in the 1970s, a contemporary homosocial *milieu* that succeeded it, and a recent moral panic that surfaced in the media in late 1999 around an alleged paedophilia ring. While the term "emerging gay communities" has been used by Parker (1998) and others to refer to the increasing visibility of "same gender loving" social

relations, the evidence presented below militates against the view of a historically unfolding and sociologically discrete community in Abidjan.

Boubar, Oscar and the emergence of the "*milieu*"[3]

The emergence of the "*milieu,*" is most often recounted as the story of two nightclubs, their owners and their patrons. No one recalls exactly how the rivalry between Oscar's and Boubar's developed; but everyone does remember that it developed during the 1970s. For most, the *milieu* was about style. Boubar's was "conservative," "old school." Boubar's "boys" — an assortment of handsome young men who may or may not have been his lovers--might have always been smartly dressed, *sapé*[4] perhaps, but they were certainly not innovative. Boubar's social circle revolved around his restaurant, laconically known as Boubar's, that served the national dish from his native Sénégal, *tiep bo djen* — fish cooked with rice, yams, squash, eggplant and sweet potato — every day at lunch. At night, Boubar's was turned into a discothèque, frequented by men and women from the "*milieu*" but also "*entraineuses*" (women hired by the bar to entice men into the establishment), their patrons, and a diverse cross section of neighbourhood characters.

Oscar, on the other hand, was "trendy." His crowd was considered "hip", more outrageous, and prone to hysterics, scandal, and drama. Oscar, unlike Boubar, eventually became somewhat famous, as stories about him appeared in the local and international press. He came to Abidjan from Mali in 1969, after failing his *Baccalaureat* exams. Once there, he developed a network of connections through his job as a hairdresser at the famous *La Coupe* hair salon in the Plateau district. Oscar's French *patronne* introduced him to her coterie, a mixed group of European socialites and bored housewives that frequented the salon and gossiped while having their hair done. Oscar was a natural confidante.

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[3] The story of Oscar, Boubar and the "scene" in the late 1970s and 1980s was pieced together from interviews with informants and Kader 1974, Paulus 1983, Mandel 1983, Le Pape and Vidal 1984.

[4] The term derives from the acronym for *société des ambienceurs et des personnes élégantes*, an urban club that quickly introduced stylish European fashion in colonial Brazzaville (French Congo) Friedman in White.

Figure 6.1 • Drag Show

At a *mardi gras* party in 1978, at the suggestion of one of his clients from the salon, Oscar rounded up some friends and put on a drag show. Oscar and his group were an instant success. The impromptu drag show quickly became a troupe, and played to packed and appreciative audiences at private soirées, even in the interior of the country. Within a year, Oscar had found a home for his *copines* — girlfriends — on the *rue Pierre et Marie Curie* in the nightclub district of Zone-4, where he set up a cabaret. The show featured his *copines* under a string of modernist pseudonyms: *Zaza Intercontinentale*, *Estella Boeing 747*, *Mercedez Benz*

281. Initially frequented by mainly European patrons, *Chez Oscar*'s African clientele grew and soon became a rival to Boubar's. The show at Oscar's featured brilliant impersonations of all the "sophisticated ladies" of African cultural life — from the traditional Baoulé singer Allah Thérèse, a favourite of Houphouët's, to Josephine Baker to Miriam Makeba ("Pata-pata") to Anglo-American disco divas Diana Ross and Grace Jones ("La Vie en Rose" and "My Jamaican Guy"). The crowd favourite was, predictably, Oscar's rendering of the Queen of Afro-zouk, Ivoirian singer Aïcha Koné.

Figure 6.2 • The I-D story.

Figure 6.3 • Oscar's troupe (From Mandel 1983)

Oscar's story was the subject of reportage in the widely-read Paris daily *Libération* in 1983 (Mandel 1983). *Libération*'s front-page story followed on the heels of a feature in *Ivoire-Dimanche*, the Abidjan weekly that was avidly read for its occasionally provocative — given the assumed prudishness of the literate public — coverage of social life in the capital. The story on Oscar, and his troupe, was remarkable in that it did not gloss over the homosexuality of Oscar, Zaza, and the others:

> "...to assert that Oscar and his troupe are homosexuals is a line that most Abidjanais would not cross. Startled by the appearance and behaviour of these young boys, certain would swear — often without the least proof — that we are dealing with a band of sexual inverts. We leave each side to its own truth, in order to remind the reader what is certain: we are here in the realm of art."

The story was widely read, and well received — in the subsequent interview in the *Libération* story, Oscar says that his African clientèle grew after the article.

That the story passed with such little notice was surprising and attests to a certain "liberalisation" of the discursive climate around sexuality. In 1974, *Ivoire-Dimanche* (popularly referred to as "I-D") had published an interview with a self-avowed Lesbian that caused a small scandal. In the interview, the young woman explained how she became a lesbian, including rather frank details of her amorous life. The story outraged *I-D's* readers, bringing a severe rebuke from the Political Bureau of Houphouët's ruling Party (the PDCI, Côte-d'Ivoire's *Parti unique* at the time) and a *mea culpa* from *I-D*'s Editor. Perhaps *I-D*'s Oscar story,

by being couched as a theatre review, passed scrutiny more easily, or perhaps frank depictions of lesbianism exacerbated male anxieties about the postcolonial economic order. When I interviewed the current editor of a major Abidjan daily who was a writer for *I-D* at the time, he told me that "mentalities had evolved," largely because stories dealing with sexuality had become more commonplace — the inevitable result of the liberalising effect of the international media.

Some remember the late 1970s and early 1980s as the heyday of the *milieu*. Oscar's cabaret did not fare well with the deepening crisis, and he moved to Libreville in Gabon in the late 1980s. Many visible members of the *milieu* died — some *perhaps* of AIDS. Boubar's *tiep* restaurant still exists but no longer turns into a nightclub. Sometime in the late 1980s he got married, had many children, and went on the Hadj, to Mecca. He died two years ago.

The contemporary *milieu*

Oscar's cabaret is no more, and though Boubar's restaurant is now run by his wife, it is only open for lunch. Other *maquis*, nightclubs and meeting places have sprung up to fill the void. While some of these are inspired by western gay establishments, either in name ("Buddy's") or in ritual (Sunday brunch), they are otherwise indistinguishable from venues that cater to less specialised clienteles, whether in appearance or in the mix of patrons. The lack of specialisation was already remarked upon in the heyday of Oscar and Boubar.

These homosocial meeting places include postcolonial versions of the voluntary associations of colonial times — clubs and nongovernmental associations. A few, like the *Association des travesties de Côte-d'Ivoire* (ATCI), are legally incorporated and make no bones about their sexual affinities. Others are informal associations of friends and acquaintances who will occasionally organise evening get-togethers or dances, collecting money to pay for renting a dance hall or purchasing food that they will cook together. In-between are organisations and associations whose *raison-d'être* is unrelated to the issue of sexual orientation, but that have nonetheless become informal meeting places for bi- and homosexual patrons. These include sports clubs, religious groups and political associations: an

impromptu gym in Abobo township, a Buddhist worship club, the neighbourhood youth wing of one of the major political parties.

These are not meeting places in the sense of "cruising grounds," where people meet for sex. Rather, they are spaces of complicity where issues of sexuality — including homosexuality — are discussed liberally. They are also informal sites of self-help, where a shared interest — politics, body-building, worship — allows the development of solidarity. In these spaces, the discourse of homosexuality is not one about sexual desire. Rather, they are places where homosexuality is discussed as one of many strategies for gaining access to a better life.

"Positive Nation" is an example of an association whose purpose is ostensibly unrelated to homosexuality, but that nonetheless functions as a quasi-public homosocial sphere. This HIV/AIDS group was founded in 1993 by a group of friends. Two of the founding members explained to me that they fought to set up the organisation at a time when few people were interested in HIV/AIDS, believing that it was "a disease of poor people, drug addicts, and western homosexuals" and that it was the responsibility of the state to deal with such public health matters anyway and that, besides, the state itself did not seem to think that AIDS was a problem. These men disagreed with the view prevalent at the time, because "many of our friends have died of AIDS." *Positive Nation* was clearly modelled on AIDS groups in the US and France that had emerged from the gay activism of the 1970s and 1980s. It had a flashy logo, and explicitly claimed an activist stake in the fight against HIV/AIDS in Côte-d'Ivoire.

It was only later, once it was clear I could be trusted, that their early awareness of AIDS derived either from being gay or having been exposed to gay identity politics, was confirmed. My suspicions had been triggered by one of *Positive Nation*'s colourful and slickly produced AIDS prevention pamphlets. The flyer contained cartoon figures to illustrate condom use. Some of the cartoons showed two men, while others showed a man and a woman. While the sexual explicitness of the educational materials was clearly inspired by posters and pamphlets the group collected from French organisations, it also mirrored a culture of sexual openness within the group. After I had begun to volunteer with *Positive Nation* and befriended Christophe and Yao, they told me their "coming out" stories. These stories are narratives that will be located within a broader environment of

rumour and gossip. As I will show, these stories occur within an ecology of discursive practices that produce knowledge about individuals, while at the same time fashioning subjectivities. Rumours transmit along, and solidify, social networks as well as being effective strategies for disseminating information that allows people to get by. These networks are material, in the sense that they can be mobilised for economic survival in the city. These constitute a *social epistemology*, that is, a way of knowing where one stands within social fields, such as the *milieu*, that are not legible in kinship terms.

"Coming-out" stories

Christophe was born in a small Ivoirian town. His father, a former French colonial administrator, married a local woman in the town where he had been posted. His mother died in childbirth, and his father died of heart disease when he was a child. He told me he found out he was homosexual when a cousin came to visit: he was 12 or 13 at the time and "we fooled around" and from then on he "knew." He has not "come out" in the western sense, although some of his friends in France know, and he has been to gay bars there. His brother, a successful businessman who supports him financially, does not know. Indeed, Christophe lives in perpetual fear that he will be found out and financially cut off. His brother supported him through law school, but he never found employment in his profession. Christophe now works for his brother full-time as a clerk in his company. He has had an Ivoirian boyfriend for two years, whom he supports: "you know, here, it's so difficult to find work."

As a young man, Christophe fell in with a circle of French gay men whom he met through a friend. This friend's effeminacy had put Christophe at ease, and he was the first person to whom Christophe confided his homosexuality. Christophe, like many *métis*, has French citizenship. and could move to France. That he hasn't is something that his boyfriends, who do not have such opportunities, do not understand. Like most youth in Abidjan, they dream of a better life in Europe or perhaps even America; the stories of stowaways killed in the undercarriage bays of

aircraft flying to Europe could be theirs[5]. Christophe told me that life for him in France would never be as comfortable as in Abidjan; he would never be able to find work, and the cost of living is so much more expensive. Besides, "I'm not interested in anything but black men," he told me. So he stayed in Abidjan.

His early twenties were a difficult period, and he despaired of ever being happy or being able to have a "liveable life." "Here it's not difficult to find men" he told me. In those early years, Christophe described to me a long series of self-destructive relationships with *petits loubards* (young ruffians), a chronicle of physical abuse and robbery, that made me think about emotional self-abuse. The ease with which he was able to meet youths was in large part due to the difficult economic circumstances the youths found themselves in. As a result, he explained, there is no shortage of what he called "economic bisexuals:" attractive, masculine young men who look to relationships with other men as a strategy for survival. In *nouchi*, the youth street-talk of the city that has come to serve as a lingua franca and a marker of *abidjanais* identity (see chapter 5), such men are referred to as *yossis*, while their effeminate lovers are *woubis*.[6]

Christophe would not be called a *woubi*: *"il n'est pas folle!"* (he's no queen) one of his boyfriends once growled at me when I asked. However, after an initial succession of disastrous forays, he lived out his homosexuality through a *woubi*-centered network. *Woubis*, the effeminate men Christophe frequented, were often popular figures in the neighbourhoods they lived in: their houses were open to local youths who could count on them sharing their food with them when there was not enough at home, and they occasionally might be treated to a beer at the local *maquis*. *Woubis* had money because they had jobs, which they had gotten like everyone else in Abidjan, through *le couloir*[7] (contacts).

For many of these neighbourhood youths, being taken care of in this manner is undoubtedly welcome (see below). They have little in the way of economic

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[5] In 2000, two Guinean teenagers were found dead in the undercarriage bay of a Sabena Airbus in Brussels — they had taped letters to their bodies saying they would rather die trying to leave Africa than stay there because there was "no future for young people" in Africa. They had attempted to repeat the exploit of a Malian youth who successfully stowed away on an Air Afrique flight to Paris. Coverage of the story crystallized the plight of African youth in the media.

[6] The distinction is explored in a recent documentary, entitled *Woubi chéri* (Brooks and Bocahut 1998).

[7] The hallway, referring to where one catches a contact with a job to hustle for work.

resources, come from large families, and find themselves increasingly marginalised in their own families as they are unable to contribute financially to the household (see Chapter 5). Moreover, "hanging out" with *woubis* promised access to wealthier homosexual men. Access was not granted easily, however. Christophe told me that these neighbourhood youths had to demonstrate that they could be trusted not to "steal at the first opportunity" and could be counted upon to perform errands. *Woubis*' visibility as presumed homosexuals ensured that the youths that courted them were not homophobic, and presumably homophilic. Some of the youths were sexually curious, and when sex was consummated they graduated to the category of *yossi*. Some *woubis* functioned as informal dating services, introducing attractive *yossis* to shyer men who were uncomfortable in public

After a few years, when he reached his mid-twenties, Christophe was tired of socialising with *woubis*. He had never been interested in them sexually, and their antics and "carryings-on" tired him. "They're all drama queens" he told me, adding that he had realised that their "introductions" were less than disinterested: he was expected to return the favour in the form of reciprocal introductions to an imagined circle of wealthy — preferably white — men who would shower youths with gifts, a portion of which would return to the *woubi* who had originally set up the introductions. He was tired of being used as a "stepping stone" and of being "constantly hit up for loans by little queens who don't know how to manage their money." (As will be discussed below, these "little queens" are actually astute managers of social networks.)

Christophe discovered that he didn't need to rely on *woubis*' networks to meet men. It was "just too easy" to proposition men he found attractive in the random contacts of everyday life: butcher boys at the market, car washers, construction workers. In exchange for a small sum to cover "transportation," men would agree to sleep with him. Perhaps because these men hadn't been filtered beforehand by a neighbourhood *woubi*, or perhaps because Christophe just "didn't know how to pick them", these encounters often turned into disasters. After a few disasters, he would turn to more reliable sources for introductions before returning to more spontaneous, and more sexually exciting, strategies.

Founding *Positive Nation*, where I first met him was a turning point for Christophe. It was in many respects the culmination of a new group of friends that he made as his contacts with the *milieu* broadened beyond meeting men for sex. Once the group was founded, its rhetoric of openness around sexuality as a strategy for fighting AIDS attracted a particular blend of individuals. One of these was Yao, a young Ivoirian man who was an early member of the group whom I first met there in 1995.

The first time I formally interviewed Yao in 1996, he had come home from work for lunch and was on the balcony of an apartment he shared with friends, busily peeling potatoes in the sweltering heat for a quick *steak-frites*. Unlike Christophe, Yao is brimmingly self confident, a handsome man whose burly frame, "in-charge" demeanour, and air of financial ease earns him the respect that is accorded to "big men" in his neighbourhood. In the neighbourhood, he is described as *en forme* (in shape) or simply *le gros* (the big one). Yao "knew" he was attracted to men ever since he was a child, growing up in a poor neighbourhood of Abidjan. His first relationship was when he was 15, with a French man he met in a park. The man brought him home and eventually took him in, paying for his education and sending him to university in France in 1992, seven years after they first met. Their sexual relationship was extremely brief — Yao refers to his man, who has since died, as his "tutor." Yao loved his stay in France, a country where "the government respects people" but returned to Abidjan to be "home" after he finished his studies.

Figure 6.4 • Making dinner

He moved in with a Dutch man he met on his return from France in 1994, and took a job in a Lebanese-run import-export firm. He told his family he was "homo." He was 27 at the time. This was greeted with general indifference. His sisters, who "adore" him, only adored him more, and two of his brothers, who never liked him anyway, decided they liked him less for it. His parents ascribed it to his European stay, and waited for the phase to pass, and for him to marry and have children. Yao often showed up at the family compound with various boyfriends in tow. They were always well-received, and treated like family friends. For some of these men, Yao's family became a surrogate family.

Yao is the youngest son of a large matrilineal family. His parents still live in the *cours commune* with three of his sisters, close to where he was born in a village not too far from Abidjan. His parents are now quite elderly: his father has some income from a small cocoa plantation; his mother is paralysed on her right side from a stroke. His two brothers have "modern" jobs: one is a policeman, the other a nurse. His mother's illness is a constant source of tension between Yao and his family. She developed her paralysis after a stroke in 1997. Yao paid for a wheelchair and consultations with a physiotherapist. The wheelchair was never used, and the physiotherapy sessions happened long after the stroke, too late for them to do any good. His mother does not go out, because the rest of the family is "ashamed" to take her out. This incenses Yao. Her hypertension is poorly controlled because, Yao says, "they treat her with traditional medicines."

I once accompanied him to the local dispensary where his brothers had brought their mother because she was running a high fever and was delirious. When we got there, she had already been discharged — the intern told us that she had developed a phlebitis in her paralysed leg and that that he had caused the fever which had brought her blood pressure up and led to her confusion, and that he'd discharged her with antibiotics. When we got to the family compound, Yao's mother was sitting up with her daughters. Yao flew into a rage when he saw that her torso was streaked with clay, a sure sign that they had bought traditional medicines.

After assisting at a number of scenes like this one, I realised that what was at stake in Yao's conflict with his siblings was his authority within the family. Advocating the use of modern medicine and a modern approach to treating her disability was Yao's way of demonstrating that he could have a role in the family even though he would not have children and was, therefore, refusing a fundamental responsibility.

In the city, Yao's charismatic personality rapidly earned him a place at the centre of a vast constellation of friends, acquaintances, fans and hangers-on. The relationship with Hans, who Yao characterises as "the love of my life", did not survive the ups and downs of Yao's tumultuous flirtations, seductions, and affairs with the succession of young men who were attracted to him. He wanted to settle down with an African man. A few months after his break-up with Hans, and after a succession of rowdy affairs with African boys, Yao told me that he "wasn't interested" in local boys anymore. They are "all the same:" either "they're just with you for financial gain" and not "truly" gay, or they are "silly queens" of whom one tires easily. By then he had launched into a new project.

Bored with his day job at the firm, Yao opened a *maquis* in the city's Zone-4 nightlife district. It was a small place perched on the side of a busy road, with low tables and chairs spilling out onto the street. Inside the simple wood structure with a sand floor, were a few tables and a bar. Behind was a simple kitchen that produced Ivoirian favourites — grilled chicken, fried plantain, peanut sauce, fries. Yao's addition to the traditional Ivoirian recipe was a chili-pepper and palm oil paste enriched with mashed garlic, briefly earning the maquis the nickname

"*Mapouka-Piment.*"[8] Consonant with his relentless good humour, charisma, and high profile in the *milieu* — the succession of dramatic affairs and scandalous behaviours helping — the *maquis* became a focal point for the *milieu*. The *maquis* was also frequented by Liberian refugees — they appreciated the generous sampling of American "R'n'B" music that Yao enjoyed cooking to — who always ordered the same thing. As a result, the "*Mapouka-Piment*" eventually became known as "*One-Chicken.*"

Figure 6.5 • Yao's poodle.

In those years when he ran *One-Chicken* all night and worked in the office by day, I often wondered when Yao slept. Evenings spent at *One-Chicken* often degenerated into long nights at tawdry zouk-bars, raucous karaoke clubs and "Lebanese" — techno — nightclubs. By then he had moved out from Hans' apartment and into another apartment, on the 12th floor of one of the modernist SICOGI blocks built in the 1970s in the *220 Logements* quarter of Adjamé township. As a housewarming present, Hans had given him a small poodle, increasing his notoriety in the neighbourhood. He moved there with a clutch of young men — cousins from the village send to live with him while they went to

[8] Mapouka is a traditional Ivoirian dance that notable for its rhythmic shaking of the buttocks. The conjugation with *piment* — hot pepper — connotes a rather spicier version of the dance that was the subject of some controversy at the time. Purists decried the new improvisations of the dance as "pornographic," while modernists pointed out that the updated dance had put Abidjan on the dance map in such hard-to-crack places as Kinshasa.

school, a succession of youths he had "adopted" in his neighbourhood encounters, and two nephews. None of them were homosexual, but they enjoyed accompanying Yao on his evenings out, and clearly worshipped him. One of his nephews went on to graduate as an officer from military college, and still comes to stay with his uncle whenever he is on leave.

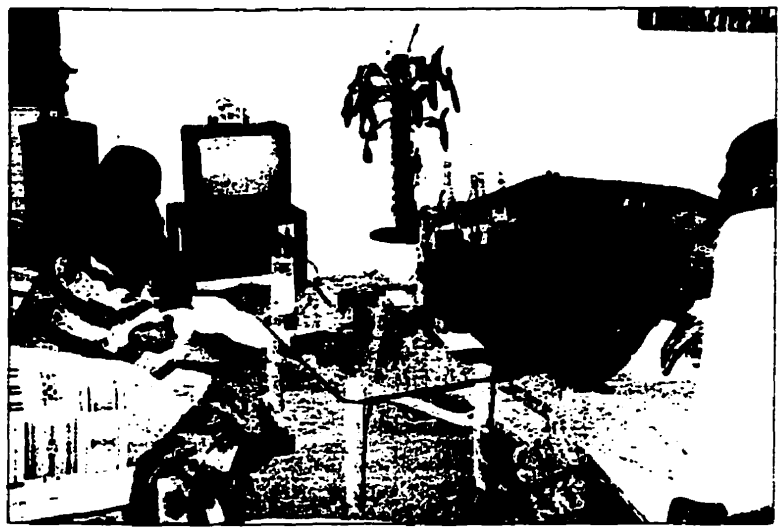

Figure 6.6 • Watching television.

Despite being on the 12th floor without a functioning elevator, Yao's apartment was the hub of a lively social scene. The various youths that congregated there were readily pressed into service preparing evening meals under Yao's supervision. During the meal, television programs were the focus of attention, and were the object of much loud commentary and gossip. Crowd favourites were the Brazilian and Mexican soap operas that preceded the evening news, second only to appearances of Côte-d'Ivoire's First Lady on the news program, regularly greeted by loud shrieks and sarcastic commentary on her hair, her skin colour ("if she uses any more skin lightener she'll peel"), and the self-serving nature of her good deeds. Things quietened down after the coup in 1999 — business was not so good, and Yao had to cut down on expenses. With less food to go around, people couldn't count on getting a meal there and dropped by less.

Talking names around town: rumouring networks

Christophe's and Yao's coming-out stories give only part of a picture of the *milieu*. Much of the social knowledge of the *milieu* comes from the stories people told about other people: stories that I realised were as much about conveying information as positioning teller, listener, and the subject of the story — Yao's infidelities, Christophe's unorthodox sexual preferences — in a broader commentary on social relations. The material implications of this social epistemology were underscored by the incidents that surrounded the circulation of a European film.

The talk of the *milieu* in 2000 was "Men of Africa," a homosexual pornographic video that had been made that year. The French producers had come to Abidjan — drawn, I was told, by the city's reputation for sexual liberalism and the assumption that actors could be easily — and cheaply — found there. Once in Abidjan, the producers used the *milieu* to find a cast of characters who were only too willing to figure in the video once they had been told of the pay — I was quoted fees of $100 to $500 depending on who my informants were — and been promised that the video would never circulate in Abidjan. Of course, once produced, the video did find its way back to Africa. Christophe, I was told, had procured a copy on one of his trips to Paris and brought it back as a trophy. The video stimulated vivid interest in the *milieu*, not least because the characters were locals and Abidjan viewers might recognise someone they knew.

Although I was not able to interview any of the actors, I heard countless stories about what happened once the video was "out." I never got to see the video — Christophe was very coy and never told me me that he had a copy. Perhaps he thought I would disapprove. Connoisseurs told me the video was cheesy and "nothing special," but much commentary was offered on the sexual performances and anatomical attributes of the characters. The local circulation of the video did have real consequences, however. One of the characters, I was told, attempted suicide — with an overdose of sleeping tablets — because he felt that his manhood had been compromised by the video and because his family found out about it. The leading character in the video was quickly nicknamed "la Star." He already had a reputation as local rough trade and sure trouble. He nonetheless became a hot property, eagerly sought out — for sex — by members of the *milieu*.

Christophe, brandishing his video, was first in line. His tryst with Star turned into a disaster. Star beat him up, and was caught with Christophe's expensive watch by Christophe's then-boyfriend, Théophile, who was returning to Christophe's apartment with his three-year-old daughter in tow. Théophile confronted Star in the living room, reasoning with him "as a brother" to give back the watch. Star was impervious to reason, and left with the watch. Thankfully, the living-room scene was not violent and no one else was hurt. Christophe suffered some bruises and a wounded ego — he never told me about the story, and I never asked. Word about the scene quickly got around town, but it didn't seem to diminish Star's desirability. If anything, it enhanced it.

Subsequently, a story circulated about how Star accepted a proposition from another man, Joseph. After undressing, Star demanded the man give him his mobile phone. This was considered presumptuous, as nothing sexual had yet happened. The confrontation once again turned violent, and in the ensuing scuffle Joseph suffered a broken wrist and Joseph's boyfriend a black eye. Star left with the phone. The bandaged wrist and blackened eye were much commented upon afterwards. Star subsequently took up with Bruno, a Congolese medical student. This lasted for some months, with Bruno squandering the allowance he got from his parents in Kinshasa for his medical studies on Star, and subsequently failing his qualifying exams. Star disappeared from circulation, and Bruno's reputation suffered.

Bruno's name was "spoiled," by what was considered his frivolous behaviour. After a while, I found out that, during the time he was "keeping" Star, Bruno was ostensibly "going out" with a wealthier man who had been supporting him, although this man was already himself involved with another young man. One informant laughingly explained to me that likely it was this first protégé who "spoiled" Bruno's name: "well, you know, it's like when you have two wives, the first wife checks on the second wife 'cause if the second wife's name gets talked around town then it's the first wife who's gonna get grief." Star eventually ended up in prison, although he was released after the 1999 coup. In the confusion of the coup, when soldiers attempted to liberate political prisoners held at the Abidjan jail, all 6000 inmates were released.

Meanwhile the relationship between Christophe and Théophile soured. They hadn't been getting along for some time, although a few years earlier Christophe told me that Théophile was the "love of my life." It seems that the turning point was when Théophile brought his daughter from his home village to live with them. Christophe was said to resent the child's presence although he seemed to enjoy playing with her when I was around them. I found out — awkwardly, before Christophe did — that Théophile's appearance with his daughter had stimulated the interest of the young woman who lived downstairs. The interest was apparently mutual, and Christophe found out about it soon enough one night when he returned home early to find the hapless neighbour drinking a glass of beer in the kitchen wearing nothing but a towel while — it was recounted to me with great hilarity — Théophile was in bed watching *Soukouss* — Congolese music — videos and smoking Marlboros. Théophile and I were never on the best of terms, so I never obtained his side of the story. Not long after the kitchen incident, Théophile's daughter moved in with the neighbours downstairs. A few months after that, Théophile moved back to the village, leaving his daughter with the young woman neighbour in Abidjan. Théophile came back to Abidjan several times, increasingly desperate for cash, pleading with his friends to arrange an introduction with an eligible man who would presumably be able to care for him.

The dizzying array of serial and parallel relationships that these stories depict reflect the Brownian motion of urban life. By espousing homosexuality as an identity and the pursuit of desire, Christophe and Yao released themselves from the social moorings that usually anchor sexual networks. Most Abidjanais look with suspicion on strangers, and require knowing "who is who" before getting involved. Knowing "who" someone is requires, above all, knowing their family. In Christophe's and Yao's case, the criteria are highly individual and express sexual desire. However, discussions of same-sex desire do not transmit easily along kinship networks. In the *milieu*, information circulates through rumouring networks where stories are addressed as discrete packages of information. Similar to e-mails, stories accumulate and are often broadcast or redirected, giving rise to a plethora of potential misinterpretations that must be navigated carefully by scrutinising them for their true intent.

Knowing "who is who" is what is at stake in this social epistemology. Opinions, gossip, and rumours about people are collected and weighed against the

credibility of the source. Credibility of information is determined by considering the social position of the source, and how the source's own interests may shade the information given. The spreading of rumours is readily resorted to in homosociality but is equally suited to situations where the intelligence required is not readily available through kinship networks. Voluntary associations like Positive Nation and other homosocial spaces are nodes in rumouring networks, where information can be centralised and correlated. Nodes can be exploited for purposes other than the circulation of information, as some examples of neighbourhood of the lives *woubis* show. Knowing "who is who" is also a key part of the informal economic strategies discussed in Chapter 5 — whom to extend credit to, who can be convinced to buy what who can be "hustled". In the city, where poverty makes everyday life precarious, knowing who is who is the key to survival.

"Economic bisexuality" and materialities of rumouring

Karim, one of Christophe's "ex's," was one of the young men Christophe referred to as an "economic bisexual." He was born and raised in Abidjan, the child of a large family that lives in one of the modernist apartment blocks in the older quarters of the city. The block has since become overtaken with the squalor of popular tenements, but the neighbourhood is lively and active.

Karim told me that he was "introduced to the *milieu*" by a neighbour, whose cross-dressing was the source of local gossip by neighbourhood youths. Many neighbourhood boys liked to go to "Suzanne's," because there was often food and drink and Suzanne was an almost maternal figure. "Suzanne" has since gone to live in Europe, but the introductions she facilitated mediated Karim's entry into the "*milieu*."

Karim's story echo those of many young men I interviewed. As discussed in chapter 5, the economic tactics that people use to eke out a living are largely a product of circumstance, of a path settled into after the trial-and-error of trying to survive in an African city. And might some of these paths lead to "economic bisexuality?" Certainly, African women who wear skimpy clothes, smoke cigarettes, and go to nightclubs are reputed to be "easy" and only to be attractive

to European men. Are good-looking, well-spoken characters like Karim purely "economic bisexuals," the male equivalent of the *entraineuses* hired to lure wealthy patrons into nightclubs?

Karim told me that eventually he would like to marry, an African woman with a good education but who was "house-bred," that is, who would make a good wife and mother. But his economic circumstances precluded it. He had a girlfriend, but right now he preferred seeing men because "with women it's too much of a problem," meaning, he explained, demands that had to be met. "You have to take women out," he explained, "you have to take care of them, and when you don't, there's always problems." With men it was different, "they take care of you...even if they don't give you money, they will buy you a pair of jeans, or take you out to dinner."

Karim's social circumstances certainly played a role in shaping his sexual trajectory. Although he had obtained the *baccalaureat*, there were no jobs for "little people" like him who did not have the connections to land a position in the government or in a private firm. Without a job, he could not hope to raise a family. Karim must have been aware of Christophe's wealthy family and the potential connections this offered. Karim's social network was not limited to the *milieu*, as he maintained an active role in a local political group. Should his party win power in upcoming elections, he might be able to get a patronage job that way. But it was through the *milieu* that Karim was introduced to Christophe, his first break at getting himself "settled" and in a position to marry.

Karim graduated to the status of Christophe's "ex" when he was replaced by Lancina. Lancina was a Burkinabè labourer on the construction site of one of the new housing developments in the sprawling township of Plateau-Dokui. Lancina had caught the eye of one of Christophe's French friends, Pierre, an expatriate manager with a multinational based in Abidjan, who was drawn to him for his stocky build, bulging muscles and tough air. Pierre developed a casual greeting relationship with Lancina whom he saw regularly as the construction site was behind his office. One evening, feeling brazen, Pierre propositioned Lancina who readily accepted. However Pierre tired of Lancina after a few months, and took a liking to Karim.

Pierre introduced Lancina to Christophe and soon enough an exchange was arranged. However, Karim didn't take to Pierre, but Christophe certainly took to Lancina. A comfortable arrangement — for Christophe — ensued, whereby the two young men alternated nights at Christophe's place. Eventually, Karim faded out of the picture as Lancina was better able to entertain Christophe's specialised sexual tastes that involved resort to exotic paraphernalia — handcuffs and braces of various kinds. It had been widely expected that Karim, as he was fundamentally a "nice boy," wouldn't make the grade, and that Lancina, who was after all "just a thug," would take Karim's place. This, in effect, is what happened.

Eventually, Karim went to work for Yao at *One-Chicken*, not far from where Oscar's nightclub used to be. That did not last either, as Karim felt "disrespected" there — Yao used to make passes at him that he resented. The last time we spoke, Karim was busy preparing for elections, and thinking of moving to Ouaga, where his Muslim name would not be a handicap. Karim told me he was deeply hurt by the way he was "dumped" by Christophe. Meanwhile, Lancina and Christophe had what appeared to be an idyllic relationship for about a year, but the latest I heard was that they are having "problems." I was told that Lancina had "fallen head over heels" for Christophe. Perhaps as a consequence of this, their sexual relationship changed and Christophe no longer found himself comfortable in the new sexual role that was being occasionally asked of him. Lancina, despite his thuggish airs and rough manners, became "clingy" and less desirable.

Karim and Lancina's sexual itineraries are the product of a journey through the social landscape of the city that shaped their sexual identity. Christophe's somewhat dismissive notion of "economic bisexuality" glosses over the complicated intertwining of emotional, material, and sexual desires that evolved for both of these men. These desires were products of circumstance: exposure to wealth, love, and possibility, and not just an expression of innate want. An important element in the social construction of these desires were the images of African masculinity projected by individuals like Christophe and Yao that their potential companions, like Karim, attempted to mirror.

Imagining African masculinities

When he was interviewed by *Libération* in 1983, Oscar dismissively referred to the common perception throughout Africa that homosexuality was a colonial importation: "it's true that in colonial times it was widespread, but it existed before. You only have to go the village, it still exists...in traditional societies homosexuality is practiced but we don't talk about it!" The ethnographic literature on homosexuality in Africa is sparse. Evans-Pritchard devoted a study to "sexual inversion" among the Zande (1971) and South African historian Patrick Harries notes that homosexuality among miners scandalised missionaries in the early twentieth century (1992). Michel Leiris, the pioneering French surrealist and ethnographic writer, makes a fleeting reference to African "pederasts" dancing cheek to cheek in a Dakar nightclub in 1929 at the outset of his journal detailing the Dakar-Djibouti expedition (Leiris 1996). Not surprisingly, these accounts are silent about whatever homosexual exchanges may have engaged Europeans.

Speaking almost twenty years later, my informants confirmed Oscar's words. But in the year 2000, it is difficult to imagine that even the most remote African village has not had significant commerce with the west. Even out-of-the-way places, even though they are marginalised by contemporary cultural and economic flows, are relentlessly shaped by the contemporary, as Tsing has shown (1996)[9]. Curiously enough, those that assert that homosexuality is a purely European colonial import to Africa agree with queer theorists who have argued that homosociality is deeply encoded into western cultural forms (Sedgwick 1990). What is at stake in these arguments, ultimately, is the manner in which masculinity is constructed through culture and, I would argue, social — and primarily economic — relations.

Karim's story is typical of how the manner in which many *yossis*, "economic bisexuals," or "ambiguous" types, perceive their entry into the *milieu* in terms of the potential for acquiring a wealthy benefactor — presumably European, but not necessarily so. The desire for a "sugar daddy" is certainly stoked by the neighbourhood *folles* — queens — who skillfully leverage local boys' perceptions

[9] This is beautifully depicted in the Cissoko film "Life on Earth," that depicts life in an "isolated" Malian village on the eve of the year 2000.

of their fabulous networks of wealth and prestige to obtain sexual favours from them.

As Christophe once patiently explained to me, local boys *passent à la casserole* — get broken in — before they ever get introduced to anyone important. Sampling by sexual brokers is of course an important business strategy, as the quality of the networks they entertain — the economic returns that can be expected from them — depends in part on the desirability and performance of the youths they can marshal for introductions. However sampling can also serve as an apprenticeship. Entry in the *milieu* also involves frank sexual talk, as well as becoming conversant with a specialised sub-dialect of *nouchi* that is impenetrable to those outside the *milieu*. The local *folle's* acerbic tongue and perceptive dressings-down teach the language of dress style and body language. Rumours and gossip — about what is whose "type," what "look" is in with whom, about sexual preferences — impart detailed knowledge of "taste." This knowledge translates into symbolic capital, as youths learn how to dress, talk and act in order to be attractive to "sugar daddies." Christophe's dismissal of bisexuality as "economic," rational and calculating, was, I found, often inaccurate. For youths, the acquisition of style was desired in terms of being "fashionable" or the pleasure of belonging to a secret community, rather than being a conscious strategy for "getting" men.

Stories about sugar daddies are rarer than gossip about "who's going with who," because they are rationed as valuable forms of local knowledge. It was a while before I was a party to these stories — the first I was able to verify concerned a Swiss who lived in a mansion in Cocody, the wealthy neighbourhood across the lagoon from the Plateau. I once went to his house, and was surprised to find that the stories had not exaggerated its opulence. From a palm-shaded garden, marble steps led up in to a vast living room, the entrance flanked by two enormous Bambara statues.

The stories about the Swiss man mainly concerned the nine young men that have, at one point or another, lived with him in the mansion. The young men bear a striking resemblance to each other, occasionally leading outsiders to assume they are all brothers. Their dress expresses a certain "*loubard*" look: baseball caps, jeans, gold chains, construction boots. The resemblance is not, in fact, familial. Rather, it is a reflection of the Swiss man's adherence to his "type" in his choice of

partner. As a result, one may occasionally hear a new face in the *milieu* referred to as a "potential Swiss," should the profile correspond . The awareness of the "Swiss type" stems in large part from stories that are told about the benefits of "Swiss patronage."

Although some of the "Swiss boys," including Yao's cousin Kouadio, no longer live in the mansion, they all retain a bedroom on the ground floor. Kouadio left after Johann, his patron, paid for his studies and set up a small electronics business that gave him an independent income, enough to marry. Kouadio still returns for regular visits. Through the connection with Yao, I was able to meet some of the boys as well as Kouadio. The contrast between the similarity of the "look" and the difference in character and aspirations belies the structuring power of, in this case, "Swiss" imaginings of African masculinity.

"Swiss patronage" is rumoured to be generous — private schooling paid for and squandered, decadent group trips to the Middle East, even cars. Many stories focus on one of the young men, Yaya, who is said to have masterminded an armed robbery. The victim was the Swiss man himself, who was dispossessed of his Mercedes and a significant amount of cash. Yaya was later arrested at a police roadblock driving the car, but his patron came and bailed him out of jail. A few years later, Yaya took the Mercedes while drunk, packed it with friends, and had a severe road accident in which several were killed. Johann had to fly back from Zürich to pay the hospital bills. Kouadio told me that story because he had to front the money so the hospital would agree to treat the injured. The mercenary "what's in it for me" attitude displayed by the older boys — of which Yaya was one — was in striking contrast to the vulnerability of the younger boys. How much of this difference, I wondered, could be attributed to their long "Swiss" apprenticeship?

The "tastes" of wealthier white men — and the constructions of African masculinity that underlie them — are disseminated as gossip through the *milieu*, in turn shaping the way these young men present themselves and construct their own masculinity. However, The projections of masculinity that disenfranchised youth appropriate and reflect back in a quest for economic and emotional resources do not only emanate from white men or sex tourists, as this entry from my fieldnotes indicates:

> Albert tells me a long story I can barely follow, triggered by a "gossips" session with Bruno, involving two Daniels (one black, one white) and various other characters of various races they are all sleeping with. Dizzying. Somewhere in there, there is a Yao connection, some guy Frantz (*métis*, French mother, Haitian father remarried to an Ivoirian woman) who has come here a couple of times and whom he has met. Frantz is 29, apparently HIV+, is kept by some older rich white man in France and had some boyfriend Ibrahim here who is in jail for stealing a car, now has a new boyfriend Charles. Frantz keeps coming here from France to run after Ibrahim who is a thug. At the same time he is keeping another ghetto boy, Charles, in an apartment in Koumassi (township). Albert doesn't know why, Charles is just a thug too, thinks he should "stay quiet" at home. Apparently Frantz showed him a bag full of pills and told him he was coming here to see if Positive Nation could help him get meds — I tell Albert this doesn't make sense since, as a French citizen, he gets antiretrovirals for free. Albert tells me that maybe Frantz is trying to make his visit seem "serious" and not that he's here to "be after" Charles or Ibrahim.

Ibrahim also got out of jail with the 1999 coup, and as a result Charles found himself out of an apartment as Frantz went back to his first love. Yet everyone agreed that Ibrahim was a rogue, and didn't understand why Frantz would run after him. Much was made of Frantz's being a rent-boy in Paris — since he had made it there, why would he be running around after African rogues in the far reaches of the townships? I eventually interviewed Frantz, after an initial and coincidental meeting when he brought Charles to me to be tested for HIV[10]. Frantz's stories about his childhood in France indicated that coming to Abidjan was, for him, a way of "figuring out" his "roots." Frantz, absorbed by his own issues of identity, and the Swiss man, who was shielded by wealth, were unaware of the power rumouring networks had to project their own desires and make their fantasies come true.

The discourse of homosexuality is not limited to the discursive differentiations of sexual desire. So far, this consideration of the emergence of a *milieu* has gone beyond evoking an idiomatic *Abidjanais* conversation with modernity to consider the pragmatics of rumour and its social epistemology. However, it could be asked what the relevance of these phenomena is outside the *milieu*. As will be shown

[10] It is common practice amongst heterosexuals to bring in their mistresses or girlfriends to be tested.

below, discourses of homosexuality do circulate in the imagined community of the Ivoirian nation. Specifically, I ask what is the work that it does in this collective space of representation? The "paedophilia affair" of 1999 furnishes a case study where this question may be addressed.

Moral panics and the popular press

The legalisation of multiple parties in 1989 ushered in an era of freedom of the unregulated press. A host of daily and weekly tabloids now thrive in Abidjan, which has a large enough literate market to support them. Most have strong affiliations to political parties and are brazenly biased in their reporting. Other than two restrained papers (*Fraternité-Matin*, and *Le Jour*) the majority are clearly in the 'tabloid' genre. In their pages, political intrigue ("Sullied Ministers off-loaded!") competes for space with scabrous affairs ("Financial scandal at the Tek Corporation: Mayor accused of embezzlement!"), tawdry crimes ("Hotel manager refuses orgy, then eviscerated by client") and lurid tales of village fetishism ("Witch doctor slices off head of child with machete")[11].

Figure 6.7 headlines

From the mid 1990s, rumours of homosexuality emerged, largely concerning shadowy figures in high places and paedophilia rings. These rumours reached a

[11] All the quotes are from the front page of Soir-Info, on dates which featured articles covering the Affaire pédophilie; respectively, the issues of 12 August 1998, 28 October 1998, 28 July 1998 and 6 January 1999.

pitch by mid 1998, when some of them started making it into print in the tabloid press:

> Next August 6th, according to our indiscreet police sources, the town of Tiassalé will be the meeting point of this country's pederasts. By holding a conference there, they wish to force the authorities to legalise their relationships by drafting a law authorising [homosexual] marriages. True or false, we'll wait and see. We'll have seen everything in this country.
>
> *Le National*, 3 August 1998 p. 12

But most newspapers remained quite staid. One newspaper reported on its own Editor's letter to the Minister of Communication concerning the First Lady:

> Raphael Lakpe writes to Boni Claverie: "Madame le Ministre, can we write that Mme Bédié is a Lesbian?"
> *Le Populaire*, 7 July 1999, p. 1

The Editor was jailed for "outrage to the family of the President." The majority of these rumours were about the nature of political power, and circulated largely outside of the printed press. The time of these rumours was one of growing malaise for the government. Houphouët's death in late 1993 was followed by the devaluation of the CFA franc, whose value was halved overnight, from 50 to the French franc to 100 to the French franc. The devaluation confirmed peoples' fears that, without Houphouët, they were now powerless in the world of international capitalism. This was, in many ways, the final confirmation that the crisis of the 1980s and subsequent structural adjustment — which for many meant that all the hopes and dreams nurtured under the "miracle" years were illusions — was not going to go away.

Selling devaluation to the public, particularly the urban public most sensitive to its impact on the cost of living, was not an easy job, and extravagant promises of economic growth were made. Not surprisingly, from a macroeconomic point of view devaluation did appear to work, rendering Ivoirian exports more competitive and kick-starting a languishing economy. But the results never materialised in everyday life, and by 1998 suspicions were high that the "devaluation bonus" had been "eaten" by those in power. These suspicions were fed by the World Bank's suspension of aid for "transparency concerns" in early 1999, and confirmed later on that year when the European Union also suspended aid after an audit revealed

that 18 billion CFA francs (equivalent to 45 million Canadian dollars) was "missing" from the Health Ministry.

In retrospect, it is tempting to see in the salience of the *affaire pédophilie* the cultural expression of the *fin-de-règne* of the Bédié régime and, indeed, of *Houphouëtiste* modernism. Corruption scandals amidst growing poverty bred an atmosphere of suspicion about the powerful that symbolically charged circulating stories of sexual transgression. Mbembe has pointed out that an aesthetics of vulgarity is the only response to the obscenity of power in the African postcolony (Mbembe 1992). It is important to note however, that Bédié's Ivoirian régime, did not have blood on its hands, unlike the Togolese régime of Gnassingbé Eyadéma (whom Mbembe was writing about). While the *affaire pédophilie* may have given voice to the widespread dissatisfaction, even disgust, with the Bédié régime that erupted into spontaneous displays of joy at the overthrow of Bédié a year later, it is important to not reduce it entirely to an expression of political dissent.

The affaire pédophilie

In August 1998, *Soir-Info*, one of the Abidjan tabloid newspapers published a *fait divers* on its front page: *"Un libanais apprehendé pour pédophilie"*[12]. The story concerned a *Monsieur Nabil*, well known in the town of Dabou, 60km west of Abidjan, because he was the owner of a local watering hole called the "TGV."[13] The story reported that he was also a "sex addict...usually able to satisfy his libido with girls rarely over 15." What had been not so well known until then — the paper reported, making the common conflation between homosexuality and pædophilia — was that he was "also a paedophile," having not been able to "escape" the charms of a 14 year-old youth. The youth, who was "very effeminate with the evocative pseudonym of *female* and whose only friends are girls," was often invited to the *TGV*, where *Monsieur Nabil* stoked his desire by obliging the youth to dress in tight jeans and "*tee-shirts très sexy*." Through the summer of 1998, the youth's health crumbled under the weight of these "abject sexual assaults," leading him to reveal all to his parents. They complained to the local authorities who then arrested *Monsieur Nabil* in August 1998. This story was not

[12] Lebanese man arrested for pedophilia.
[13] The acronym of the French high-speed "Train à grande vitesse."

published by any of the other papers; perhaps not surprisingly, as *Soir-Info* has a reputation as trying to "use the homosexuality angle" to sell newspapers while the others have different marketing strategies. *Soir-Info*'s sarcastic reporting of a transvestite meeting in 1994 so enraged the transvestites that they descended on the newspaper's offices the next day, assaulting journalists and breaking a number of windows (Reuters, Abidjan, 14 September 1994). This was, in fact, the event that precipitated the formation of the Transvestites' Association (ATCI).

Two weeks later, President Bédié announced a cabinet shuffle in which seven Ministers lost their portfolios, including the Minister for Economic Infrastructure. A week after the cabinet shuffle, *Soir-Info* reported that the affair of the "pædophile arrested in Dabou" had rebounded, with the arrest of the two of the presumed paedophile's brothers. The brothers were suspected of having incarcerated a young girl because she "knew too much" about their brother's activities, and they wanted to intimidate her into silence.

Until then, the story had simmered on the *fait divers* pages of *Soir-Info*; but it took a dramatic turn on 5 October 1998, a few days after the file was transmitted from the Dabou police to the Abidjan office of the *Procureur de la République*[14]. *Le Jour*, a respectable daily and a leading opposition paper, headlined its front page with "14 year old adolescent repeatedly sodomised; prominent figures cited" and, in subtitles "UAA, a 14 year old youth, and pupil in a secondary school in Dabou...has been the victim of paedophilia on the part of a group of persons including the Minister for Economic Infrastructure, the Lebanese Ambassador, and several other prominent figures." The paper interviewed UAA and published the transcript:

> Everything began in December 1997
> ...on 24 December, my grandmother, with whom I live, being absent, I went out with friends to go to a year's end party, in the quarter of Tchotchora...once there, I meet Donguigui, another youth from my quarter. He introduces me to Monsieur Nabil, the evening's sponsor. The latter seems very nice; he asks me to call him the next day, but that day, I am exhausted from the previous evening's party, so I don't call.
>
> Saturday 27 December

[14] Crown prosecutor.

2 pm: Monsieur Nabil is on the line, he introduces himself as a businessman. He asks what size I am so that he can buy me some shoes as a gift. He is the owner of a nightclub in Dabou. He asks that I come by and visit him in his nightclub; he promises to introduce me to good people.
10 pm: my grandmother falls asleep. So now I can go out and meet Monsieur Nabil at the agreed-upon place. He is in front of his nightclub, leaning against his car, a green BMW. Inside the nightclub, I am introduced to a crowd of persons, mainly Lebanese: among them, Irda, Jamal, Sami, a certain Manadja, Eric Mary (who would be the hairdresser of Mme HKB, wife of the President of the Republic of Ivory Coast), Evariste, Ali, Adibe, Youssef and Emmanuel, who is the manager of the night club "Karaoké" in Abidjan, phone number 51-52-53. This glamorous crowd is conversing around a carton filled with bags containing a white powder, which they share. Nabil takes me upstairs to the bar. He offers me a drink, a Gintonic, in which he pours the white powder. He explains to me that the effect of the powder is to attenuate the alcohol level of the Gintonic. Reassured, I drain the glass. A moment later, my head becomes heavy. We leave the bar. Nabil takes me to his home in his car. Once in the living room, I fall asleep in one of the chairs. Around 4am, I open my eyes. I discover that I am naked. I have aches all over my body. Nabil asks me to get dressed, threatening me not to tell anyone [*sic*]. Otherwise he'd have my hide. Then he brings me to my grandmother's, around 5am.

Saturday 14 February.
Manager calls me on Nabil's behalf, demanding that I come to his nightclub around 8pm. My grandmother being out, I go to the rendez-vous. But surprise, Nabil is not there. I am greeted by Sami, Jamal, Majeb and Manadja. They make me get into a black Mercedes. Several minutes later, we are in Abidjan. I am in a nightclub in Marcory which is called Karaoké: it is here that Nabil will greet me. He introduces me to new people, including the Minister of Economic Infrastructure and the Lebanese Ambassador. First, they seat me in one of the sofas. Then Boustany Nabil brings me into a room. Nabil Zorkot, Erica Mary, Emmanuel Thompson, the Minister and the Ambassador join us in the room. In this cell, the walls are plastered with photos of naked people. There is also a bed and some chairs. They sit me down in one of the chairs. Nabil Zorkot grabs a syringe and injects a liquid into me. Then, Thompson massages my body. Then, all the persons I have mentioned begin to make love to me. All at once. I cannot react, as the injection has completely weakened me. At the end of the sexual act, Monsieur Zorkot once again injects a liquid, into my right arm. Towards 5 am, Manager, Boustany Nabil and Emmanuel Thompson bring me into the black Mercedes, to bring me back to Dabou.

Following the article, six of the protagonists named in the story were arrested; the mother of one of the men suffered a heart attack during the arrest and died a few days later. The paper published a certificate from Doctor Kouadio Yao, of the Dabou Hospital, certifying that the boy had been "repeatedly sodomised." Two days later the Minister sued the paper for libel; the Ambassador held a press conference pointing out that he had been out of the country the day of the alleged assault.

The affair attracted banner headlines ("Minister declares: I am Not Homosexual"; "Paedophilia in Côte-d'Ivoire: the World Scandalised") as well as copious comment. Parallels were drawn with Marc Dutroux, the Belgian paedophile who had killed scores of young girls under the noses of the Belgian police. In letters to the editor, "man-in-the-street" interviews and quotes from prominent figures, Ivoirians expressed their horror. Many noted that this was contrary to African traditions, a sign of moral decay, and that Lebanese clearly felt licence to do as they wished in Côte-d'Ivoire.

The affair also took on a political air. The PDCI closed ranks around the accused Minister, supporting his libel suit, arguing that the accusations were a political dirty trick. Opposition papers played up the affair,with comments such as the like "and let's not forget this is all happening under the Bédié régime." Delegations from political parties and youth groups visited the "young sodomite" to express their moral support. One observer noted that this "is not just a banal homosexual incident"and that the conflation of paedophilia with homosexuality is widespread. "Homosexuality and lesbianism have rotted the social body to the point where organisations like the Transvestites' Association of Côte-d'Ivoire can set up shop unopposed."

The affair dragged on for the rest of the year, with the Minister finally winning his libel suit against the newspaper. A total of seven men who had been arrested were eventually released. Eric Marey, the French hairdresser, fell ill during his prison stay and died a few days after being let out to be taken to the hospital.

Witch-hunts

UAA's testimonial recalls the vampire rumours that swept through Africa in the interwar period, as part of a tide of colonial objects and practices. Luise White has pointed out that all-too-real airplanes, cars, fire engines, and injections-into the neck to siphon off lymph fluid for sleeping sickness eradication campaigns,-furnished a rich repertoire of signifying material for commenting on the extractive and life-threatening reality of colonialism (White 1993a, 1993b, 1995, 1995a, 1995b). Mercedes with windows tinted black, white powders that paralyse the body but do not blot out consciousness, injections, penetrations, and miscegenations of all sorts — African, European, Lebanese — certainly gave UAA's testimony a rich signifying potential. As noted above, the story gave voice to concerns of moral decay and social change that are not unique to Côte-d'Ivoire.

The reality was both more mundane, and more complicated. UAA, it turned out, was known within the *milieu* as a "twisted little queen," a manipulative character "not to be trusted" who was not a minor and was certainly being manipulated by political forces, likely exploiting his reputation for material gain. Marey's death shook the *milieu*, and for a while clubs were shunned as many feared a witch-hunt. "It doesn't take much to stir things up around here," I was frequently told.

Given this knowledge, why did *Le Jour* publish such an outlandish story? The editor explained to me that "we had to," since the initial arrest of *Monsieur Nabil* was public record and the subsequent explosive declarations accusing the Minister and the Ambassador. One prominent feminist activist I interviewed, who has been particularly outspoken in denouncing an "epidemic" of sexual abuse in Ivoirian families, told me that she felt there was something "not straight" about UAA when he came to seek her support for his case, accompanied by his father. "He wouldn't look me in the eye," she noted.

I eventually tracked UAA down, but never got the chance to interview him. The rumour network of the *milieu* had located him in an anonymous track of one of the newer townships, where the roads are not yet paved and impromptu housing fills in the space between half-finished apartment blocks. UAA had taken to wearing obviously effeminate clothing, I was told: flared capri pants, slip-on wedgies and even, once, a simple *pagne* wrapped around the waist. Around the

neighbourhood, he was a curiosity, a source of gossip. My contact did not want to have anything to do with him, precluding any chance of an introduction. "People say he's just like that....but I don't want people thinking *I'm* like that" my contact concluded firmly.

Conclusion

A historical consideration of the emergence of sexual modernity is empirically limited to observing a gradual proliferation of discourse about sexuality through the 1970s and 1980s, and shifts in the way homosexuality was discussed. The content of this discourse suggests that sexuality was an idiom through which concerns about modernisation, and particularly about the growing power of women, was expressed. To date, no oral history exists that allows us to get a glimpse into how sexuality may have changed and was experienced in everyday life — a project that is feasible enough given the time period under consideration here, and whose relevance will become clear in the next chapter.

Consideration of today's homosexual *milieu* in Abidjan shows that discursive practices — narratives of "coming out," rumours, and gossip — cannot be isolated from the way in which individuals come to experience themselves as sexual subjects. The way in which people imagine themselves, and their sexuality — as a true," inner identity" that is "uncovered" at key points in time, sometimes simply as sexual or romantic fantasy, or as a dream of being emotionally and materially taken care of — structures their rapport with the social world around them and helps to construct social, and sexual networks. A key point for our concerns here is that these processes are highly variable from one individual to another. That individualisation, and the diversity of sexual desire that is given expression through it, leads to sexual networks that span very different social worlds.

The consideration of the milieu points to the capital importance of rumour. Rumouring is not just frivolous gossip, nor is it a "hidden transcript" (Scott 1990) that allows people to quietly criticise those in power. Pleasure and power are key elements of rumouring, but in an urban setting they are important

sources of knowledge. The cheek-to-jowl social inequality of the city means that getting food into one's stomach, or perhaps even getting rich, is just a story away — a story that can net a sugar daddy, or a good scam, or a business secret, or a miraculous cure, or where one might have dinner.

Chapter 7
Therapeutic economy and the political space of health

Introduction

This chapter will demonstrate that a liberalised health sector put into practice in an era of economic retrenchment led to increased irrational use of biomedicines and the proliferation of unregulated injectionists. My hypothesis is that this amplified the spread of HIV in Abidjan through (1) widespread re-use of needles for injections both by injectionists and within an underfunded public health care sector and (2) inappropriate treatment of sexually transmitted infections (STIs), leading to an epidemic of asymptomatic, chronic STIs. This situation was contingent on the socio-economic changes resulting from state modernisation policies (chapter 4) and the subsequent economic crisis that led to state and retrenchment and the expansion of the "informal economy" (chapter 5). These changes, contemporary with the structural adjustment of the Ivoirian economy, ushered in a therapeutic modernism, whereby resort to biomedicine was

widespread, despite the absence of functional biomedical institutions that ensure rational use of biomedicine.

This discussion draws on the concept of *therapeutic economy*, which is used here to refer to the totality of therapeutic options in a given location as well as the rationale underlying the patterns of resort by which these therapies are accessed. These therapeutic options comprise the practices, practitioners, and forms of knowledge that sufferers resort to in order to heal affliction. In this sense, the notion of a therapeutic economy builds on ethnographic studies that have taken medical pluralism as their object of scrutiny (see Lock 1980, Brodwin 1996).

Individuals whose therapeutic trajectories I traced through NGOs, the *milieu*, and the clinical sites where I worked as a physician, resorted to a diversity of medical and healing traditions. However, while the notion of medical pluralism reflects the reality of researchers working in areas where medical systems are highly institutionalised, for patients and, as I found out, even practitioners in Abidjan, the boundaries between medical traditions are permeable. The degree of therapeutic syncretism and hybridity in Abidjan is striking. For instance, African herbal remedies are produced and packaged like western medicines, and churches are organised like hospitals (see below). In this setting, devoid of medical "purities," I found that the notion of the economic (that is, finding the most efficient means to an end) furnished the common denominator to care-seeking *and* care-giving, even if the objectives of treatment are different. In the case of a care-seeker who seeks relief and a caregiver who seeks profit, both participate in a common economic calculus even though resort occurs within a therapeutic field marked by asymmetries in knowledge and power. Patients do not have the resources to be critical consumers of therapy, and in a setting marked by poverty and desperation practitioners are rarely held accountable for therapeutic results.

The term 'therapeutic economy' emphasises the link between therapies and wider economic and social relations. Therapy always involves a form of exchange and is embedded in "regimes of value" (Appadurai 1986). Exchange may be monetary, as in the purchase of medicines, or it may constitute "moral economies" as individuals call on networks of obligation and reciprocity to negotiate access to

therapeutic resources[1]. This explains the constraints that shape therapeutic itineraries. The manner in which individuals access therapy has also been a staple of medical anthropological studies of patterns of resort, also called therapeutic itineraries. Multiple medical traditions could be accessed either serially or simultaneously. These have drawn attention to "therapy managing groups" that debate options and make decisions on both economic and cultural grounds about which practitioners should be consulted and when (Janzen 1978, Augé and Herzlich 1984).

Therapy managing groups are sites of conflict and consensus, where the relative efficacy of different medical traditions, presumed aetiologies, and previous experiences with therapy are debated. For instance, a classical therapy managing group would involve elders in a family who might discuss the aetiology of a daughter's illness — is it witchcraft or malaria? These discussions may involve appeal to cultural beliefs about disease aetiologies, or they may be simply pragmatic. Etiologic diagnoses are used to make decisions about what may be the most effective therapy, and who the most proficient therapist might be. Such decisions are not purely "cultural," however, as which view prevails is a product of its advocate's social position in the family, her economic influence, and perceived social capital (that is, her ability to mobilise social resources or to influence other family members).

The therapeutic economy in Abidjan, as an integral part of the urban cultures discussed in chapters 5 and 6, is *modernist*. That is, although "modern" medicine (biomedicine) is dominant — whether in market share, financial turnover, consumption practices, or therapeutic itineraries — it is not embedded in a network of institutions that ensures its rational use. This failure to embed biomedicine in rational social institutions marks a therapeutic incoherence that is analogous to the processes of arrested modernisation — and robust modernism — that were discussed in the previous chapters with particular reference to urban planning, education, economics, and sexuality.

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[1] The notion of a "moral economy" draws on Thompson 1971. Thompson shows how capitalist markets brought into conflict different régimes of value. I use it here in a somewhat broader sense, to draw attention to how different social relations produce value. (Weiner?)

The "market" for therapy is socially embedded. Fassin (1996) has drawn attention to this embeddedness by defining the "space of health" as a *political* one. This space can be thought of as three-dimensional, traced out along three political axes: the legitimation and exercise of therapeutic power by practitioners; collective responses to misfortune such as the institutions of public health or "traditional" systems for managing affliction; and the manner in which power embodies social relations by distributing diseases differentially across groups. Drawing on Foucaultian notions of power, Fassin shows how the politics of health extend beyond state policy and practices to include a diverse array of struggles over therapy as outlined above: therapeutic power, collective responses to misfortune, and the embodiment of social inequality.

Fassin's notion firmly places affliction in the realm of politics and history. This contrasts with an ontological approach to suffering as a defining condition of human experience. In this view, what is ultimately at stake in the quest for therapy is existential meaning. This phenomenological view has gained currency amongst several influential medical anthropologists largely working in North America biomedical settings (see, for example, Good 1994). Interestingly, relief of suffering is not the primary objective in Abidjan or Ouagadougou, where it is relief from physical symptoms and material security that were primarily at stake in patients patterns of resort. Meaning, as will be shown in chapters 8 and 9, is a subsidiary concern, most often deployed in instrumental terms to access therapy. That is, membership in churches or NGOs rarely represents adherence to a religious or institutional ideology. Rather, it is a strategy for obtaining resources.

The political space of health, and the therapeutic economy it contains, has a genealogy. That is, it emerges from a plurality of historical strands — struggles, misunderstandings, collaborations — that changes over time have intertwined in accidental ways. Plotting out the genealogy of the political space of health is analogous to showing how the urban space of Abidjan was produced. As we saw in Chapter 2, this was the result of a concatenation of colonial practices of government, political economy, and "native" engagements with modernity that fashioned new forms of social relations and strategies of economic and demographic development. The account below sketches out how some of these strands have sedimented in the contemporary therapeutic economy of Abidjan. First, the legacy of colonial biomedicine then postcolonial attempts to develop a

modern health care infrastructure, and subsequent attempts at rationalisation will be outlined. Second, the contemporary therapeutic economy will be discussed.

Colonial biomedicine

Although the *Assistance médicale indigène* — indigenous health service — was created before World War I, its impact on native health, in Côte-d'Ivoire as well as throughout French West Africa, was limited (Chapter 2). Despite the existence of this rudimentary public health system in the colonial period, it was little used by Africans although services were offered free of charge. Initially, this was undoubtedly due to Africans' suspicions of colonial authorities; however, there is also no doubt that the limited capacity of the AMI and a sparse geographical distribution also played a role.

Ivoirians' initial lack of confidence in biomedical intervention stemmed from their first encounters with colonial public health. In the 1920s and 1930s, mobile teams scoured the countryside screening for trypanosomiasis by lining up villagers and palpating their cervical lymph nodes (see chapter 2, Figure 2.10). Those with swollen nodes had their lymph fluid sampled with a needle aspirate. People found to have the parasite were subjected to painful and, it turned out, largely ineffective injections. As a result, during this period villagers often fled into the bush when word spread that public health teams were in the vicinity. Some Ivoirians even had their cervical lymph nodes excised by charlatan surgeons to avoid the injections (Domergues 1986)

Gradually confidence increased. Biomedical advances in the treatment of infectious diseases, heralded by the arrival of antimicrobials, swayed Africans, particularly given that malaria was a highly visible cause of mortality. Urbanisation also had an important impact. In the city, patients came voluntarily to seek out health care, rather than the other way around as was customary in the country, presumably instilling a dynamic of confidence.

Postcolonial health care

As with urban planning and education, the first decade after Independence saw an ambitious expansion of modern health care, with significant investments in infrastructure. The *Faculté de médecine d'Abidjan* was established and set about training a new generation of African physicians. The Faculty, and the new hospitals that were built, were almost exclusively run by French *coopérants* . Staff who had been in the former colonial service and the military predominated, and as during the colonial period, health care workers were almost all military personnel. Since training in tropical medicine was taught in military academies, even civilian health care workers were imbued with military discipline and ideas.

A significant number of the French who came to settle in Côte-d'Ivoire after Independence were *pieds noirs*, French who had been displaced from Algeria subsequent to a bloody war of liberation that ended with Independence in 1962. They had found the professional and political climate unwelcoming when they returned to Metropolitan France. The large French expatriate community in Côte-d'Ivoire remains politically conservative to this day, much more so than in metropolitan France — the racist *Front National*, for example, garners a greater percentage of the popular vote in this community that almost any *commune* in France[2].

This is reflected in a conservative medical culture that is heavily biased towards curative interventions and a hierarchical teaching and management style. Moreover, Houphouët, himself a physician, took a direct interest in the medical school (Bondurand, personal communication). Government health policy expressed a modernist option in its preference for technology-intensive curative biomedicine over less infrastructure-intensive health care delivery that could have reached more individuals for less cost. This reflected a widespread confidence in biomedicine throughout the postcolonial world in the 1960s. At the time, the new nation-states were still flushed with the optimistic projects of nation-building, and biomedicine was entering the golden age of therapeutic progress. In the early

[2] The exact number of French expatriates is difficult to determine, as the French Embassy currently counts 20,000 nationals but does not distinguish between expatriates and locals who have double (Ivoirian and French) citizenship.

years of Independence, biomedicine was emblematic of the potential and promise of modernisation, and of the future of the Ivoirian nation.

For postcolonial Côte-d'Ivoire, investing in modern health care made eminent sense for two reasons. First, health care would translate into better health for the population and, therefore, improve its economic productivity — a belief that recapitulated colonial arguments for investing in health after World War 1 (see Chapter 2). And second, the health care sector would be a motor of employment, able to absorb the newly minted technocrats, technicians, and medical specialists that the educational system — itself disproportionately weighted towards higher education — was producing. This was to have lasting consequences on the therapeutic economy in Abidjan.

In hindsight, it is now easy to see that it would have been more "rational" to invest in other mechanisms of health care delivery, as some socialist countries did by opting for "barefoot doctors" and community-based primary health care. However, at the time, developing countries did not yet understand that the logic of the global economic system would effectively make it impossible for them to afford the benefits of modern biomedicine. Continuing colonial health policy, at the point when the harshly imposed public health campaigns of the interwar period were finally paying off (in terms of decreasing morbidity and mortality from trypanosomiasis and leprosy) made eminent sense, and therapeutic optimism was rampant.

Access to health care was a clearly expressed political demand on the part of Africans. As discussed in Chapter 4, After World War 2 and the Brazzaville conference where Charles de Gaulle granted limited self-government to the colonies, African deputies were elected to the French National Assembly. As a result of their newfound political influence, French African citizens' rights in the colonies to treatment equal to that of citizens living in Metropolitan France was recognised by the Lamine Gueye law of 1950. This included a provision stipulating access to health care for all colonial citizens.

Unlike many other African countries, in Côte-d'Ivoire the presence of an industrial base afforded a significant number of African workers access to biomedicine through the workplace from the postwar period on. Independence

from France in 1960 did not affect the continuity of health policy. As in most other areas, the juridical framework governing health care remained in place, guaranteeing in principle equality of access to health care. An ideological commitment to biomedicine was perhaps best illustrated by the Ivoirian government's decision to extend free health care — including medicines — to all its employees.

The centralisation in Abidjan of biomedical infrastructure, political power, and the resources to access biomedicine, laid the foundation for a lasting biomedical hegemony in the city and its hinterland. In case of illness, resort to biomedicine became the norm. Moreover, the most modern forms of biomedicine are sought out — notably, hospitalisation, tertiary care, and patented medicines. For example, to this day Côte-d'Ivoire remains the *largest* market for patented pharmaceuticals in sub-Saharan Africa, excepting South Africa — larger than Nigeria, for instance, which has almost ten times the population, and which produces its own medicines. In the political space of health, biomedicine was the modernist corollary of the grandiose urban planning of the postcolonial period. Like the modernisation programme, however, health care policy was compromised by economic developments.

Early attempts at reigning health care costs: the 1970s

As was the case for education, it became clear early on after Independence that the policy of aggressive medical modernisation would not be sustainable[3]. Even during this time of economic growth, health care costs were outpacing both inflation and the growth of the state's budget. As a result, the government sought to decrease expenditures starting in 1970, a few years after it had slowed down investments in the education sector, and fully 8 years *before* the World Health Organisation (WHO) advocated the shift to primary health care at the Alma Ata Conference.

[3] Some have argued that decolonisation was the economic consequence of France realising that the entitlements generated after Brazzaville would result in commitments to social spending that would make the cost of keeping the colonies prohibitive. Cf Marseille 1984.

However "rationalising" the public health care system — finding more efficient ways to deliver more effective health care — proved difficult. By 1970, the health care system was a juggernaut. The highly visible infrastructure that had already been built was largely in Abidjan. At that time the city was home to one eighth of the population, but had half the physicians, one third of the nurses, and almost two thirds of the midwives in the country. The segments of the population that had access to health care were those to whom the government was the most politically exposed: civil servants — including, of course, those who implemented health care policies! — and the residents of the capital city, where the potential for civil unrest could be the most disruptive, as shown by the "sans-travail" demonstrations of 1969 (Cohen 1972, 1974). As a result, this made it difficult to implement policy reorientations that would favour rural primary care or even health care directed at improving access for the poor in urban areas, as the context of cutbacks meant that the current beneficiaries of the health care system would suffer.

In addition, the entitlements appointed to the current employees in the system meant that a large part of the health budget was already spoken for. Moreover, the future generations of health care professionals being churned out by the Faculty of Medicine presented a growing political problem, as it was expected that the health care system would continue to absorb them. Substantial health care cuts were implemented nonetheless, and the share of the state budget devoted to health went from 10.6% in 1970 to 7.5% in 1985, and dropped further to 7% in 1988.

Not surprisingly, cuts were implemented slowly and it was the established constituencies of the medical system — the urban middle classes and those already employed in the public health system — that were the most shielded. But one result of the early scaling back of state investments in health care did affect everyone — this was the termination of free medicines. As a result, the state's *fonctionnaires* — civil servants — set up the country's first insurance scheme, the *Mutuelle générale des fonctionnaires*, to cover medication costs.

The economic crisis and the collapse of public health: the 1980s

While state retrenchment in the health care sector began before the crisis of 1979, the public health care system in Côte-d'Ivoire essentially collapsed in the 1980s with the implementation of structural adjustment measures. Investment in the public health care sector declined dramatically, as expressed in percent of GDP invested in health. This was compounded by a decline in GDP during this period. "Cost recovery" measures — user fees — were implemented at the behest of the World Bank in an attempt to generate revenue for the system and to improve services, the assumption being that paying users would demand better accountability. The result was that the public was being asked to spend money on health care that had up to that time been free, while both the quality of that health care and the financial resources of individuals — and as a result most likely their health--declined dramatically. Services did not improve appreciably, and studies done later on showed that much of the fees collected either went back to the central administration or were stolen, betraying the original intention of cost recovery (World Bank 1996).

In addition to the imposition of user fees, liberalisation of the health sector was proposed by the World Bank as a measure to remedy the declining capacity of the public health care system. Although these measures were implemented slowly, suggesting some resistance on the part of the Ivoirian ministries, the health care market was liberalised through the early 1980s. Significantly, this allowed the opening of private pharmacies and dispensaries. Prior to that, only two private clinics had been authorised to operate.

The pressure to liberalise health care did not only come from the World Bank — it also came from the medical establishment. Hiring freezes meant that new graduates of the Faculty of Medicine, which had opened in 1966, were unable to get jobs in the public sector. Houphouët, a physician himself, was not insensitive to demands that young physicians be "allowed to earn a living." Moreover, the Faculty of Medicine was an important symbol for Houphouët and the country, locked in a rivalry with the older Faculty of Medicine at Dakar, which was the successor to the former colonial African medical school, the *École William Ponty*, from where Houphouët had graduated.

The medical establishment was well aware in the early 1980s that the hospitalocentric bias of the health care system and the gradual imposition of user fees was generating significant barriers to access, particularly for the poor populations that lived further and further away from the hospitals in the sprawling townships. Liberalisation — allowing physicians to open private offices and charge what the market would bear — was believed to be the solution. As a former Dean of the medical school explained to me, the idea was that young physicians would set up offices in the townships, and would still make a good living because lower consultation fees would be made up by high volumes. A number of clinics were set up with state help. However, the plan was a flop. Physicians did not want to work in the townships. From interviews with physicians and other health care workers, the reasons were partly economic and partly inherent to the élitist "culture" of biomedicine in Abidjan.

Even younger physicians perceived that pay would be better if they stayed in the central districts of the city and competed for the wealthier clientèle. One senior official, who has no love lost for doctors, told me that Ivoirian physicians do not want to "*soigner du Mamadou*" — treat Mamadous; that is, poor Muslims from the North and from Burkina. Many physicians I interviewed expressed their frustration with working with a poor clientèle — after all, they told me, as physicians they were "intellectuals" trained in the most modern medicine and not "social workers." These patients, they explained, often did not understand, did not follow instructions, and did not come back for follow-ups.[4]

By the 1990s, it could be observed that the Ivoirian state's attempt to build a modern health care system in a precarious economic context had been a mitigated success. Against the backdrop of a crumbling public health infrastructure, biomedicine still exercises a hegemonic influence today on health care and therapeutic resort. The elitist culture of biomedicine has been compounded by increased inequality in access to health care and the consequences of these changes in the contemporary therapeutic economy are explored below.

[4] Interestingly, the difficulties and frustrations of working with the poor did not come up nearly as frequently in interviews I conducted with physicians trained and working in Burkina Faso, a much poorer country whose medical school's first graduating class was in 1990.

The therapeutic economy in the late 1990s

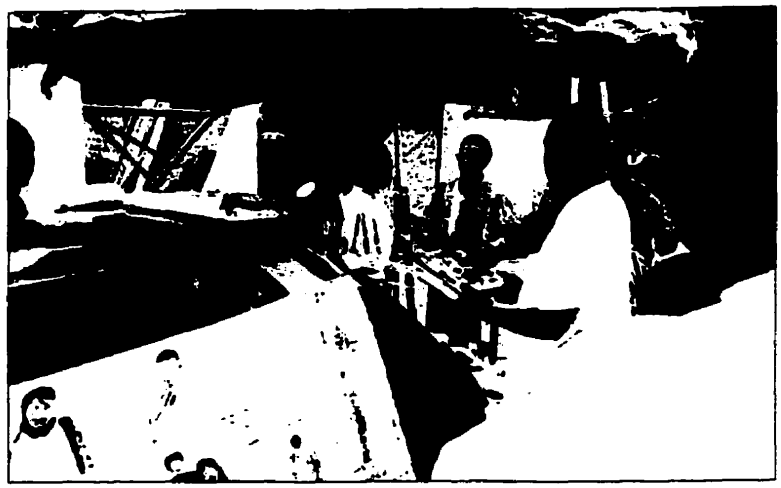

Figure 7.1 • Traditional medicines for sale outside the main tuberculosis clinic in Adjamé (Abidjan)

Medical pluralism is the norm in urban areas throughout the world, and Abidjan is not an exception. The predominance of resort to biomedicine — by far the most expensive form of treatment available — is striking for an African city where poverty remains widespread. While a detailed consideration of the medical pluralisms and patterns of resort that exist in this city is beyond the scope of this research project, I will briefly offer an account of its therapeutic economy.[5]

As defined at the outset of this chapter, the term "therapeutic economy" designates the totality of therapeutic options in a given location, and the strategies used to access them. This has the benefit of emphasising the transactional nature that constrains and directs sufferers' patterns of resort. That is, therapy always involves some kind of exchange, whether monetary or in other forms of personal debt. A therapeutic economy comprises divers medical traditions that may each be divided up into sectors, representing subspecialisations of professionals and/or points of access. Biomedicine, for example, is a medical tradition that comprises a hospital sector, pharmacies, injectionists, midwives, and so on. Table 7.1,

[5] For studies of patterns of resort and medical pluralism in Abidjan and Côte-d'Ivoire, see Vidal 1996...

although not exhaustive, summarises the most common offerings available in Abidjan's therapeutic marketplace:

Table 7.1 • Organisation of the therapeutic economy in Abidjan

Biomedical				Nonbiomedical
Public	Private		Informal	
Non-profit		For-Profit		
Hospitals Dispensaries Maternities	NGOs Mission hospitals	Private clinics Pharmacies	Infirmaries Injectionists Lay pharmacies	Traditional Chinese Medicine African herbalists Ayurveda Healing churches Psychotherapy circles *Marabouts* *Désorcelleurs*

With the exception of Traditional Chinese Medicine (TCM) and various healing churches, none of the "nonbiomedical" systems is differentiated into sectors. Traditional Chinese Medicines, however, are sold in marketplaces, in TCM pharmacies, and even in a few small TCM hospitals. Healing churches may be — most commonly are — storefront prayer halls, but larger churches have therapeutic communities that usually extend outside the city. One of these has been the focus of an extensive interdisciplinary ethnographic study (Piault 1975).

Public health care

The legacy of health care and the ensuing cutbacks is a striking one. The earlier emphasis on specialised tertiary care remains clearly visible. Two of the city's three hospitals — in Yopougon and Cocody — are imposing modern complexes built by the French. The Yopougon University Hospital was the last built, in the late 1980s. Even before it opened, most of the equipment the French had installed had been stolen. The Cocody University Hospital, next to the Faculty of Medicine, suffered a similar fate, but has recently been rebuilt by the Japanese. The older Treichville University Hospital — the former Infectious Diseases Hospital — sprawls over a large campus and is similarly decrepit. Most of the beds in the Infectious Diseases wing are closed, because there is no money to fix the roof, which leaks whenever it rains.

Despite being dilapidated and staffed by overworked and at times hostile personnel, public health care facilities charge consultation fees that are beyond the reach of most Abidjanais. These range from 2000CFA for a generalist consultation to 12000CFA for a specialist consultation — in a city where 50 000 CFA is an average monthly salary, and lunch costs around 300CFA. There is no public health care insurance. The lack of insurance and the expense of a single consultation constitutes a significant barrier to regular use by the average Abidjanais, but does not stop pharmaceuticals being bought by patients, who simply bypass the public health care system in order to cut costs. Although 91% of consultations still occur in the public health sector, biomedical consultations represent a minority of the means by which patients obtain pharmaceutical drugs, as can be shown by the tiny expenditures on consultation fees relative to pharmaceuticals in the table below.

Table 7.2 Household expenditures for health in 1995[6]

Monthly household income	Very poor <94 600 CFA	Poor 94 600 - 144 800	Above poverty line >144 800
Pharmaceuticals	1,440	3,708	15,255
Traditional medicines	260	432	2,024
Consultation fees	87	199	1,547
Preventive consultation	113	103	384
Hospitalisation	0	360	2,209
Consultation with healer	0	34	381
Other healer costs	89	329	845
Transport	3	54	860
Subsistence	74	213	6,637
Total medical expenses	2,057	5,412	28,503

Primary care facilities are few and far between. The city's two largest townships are Abobo and Yopougon, each with a population estimated between one and two million. There is no public hospital in Abobo, and only two public maternity and six vaccination centres in Yopougon. These facilities are badly ill equipped. Frequent shortages of sterile gloves are the norm; midwives deliver babies bare-handed, and most maternity units do not have a blood pressure cuff. Staff are overworked and burnt out. I interviewed one obstetrician-gynaecologist, a South African woman who had pursued her medical studies in the Soviet Union after she was exiled because of her involvement with the African National Congress. She told me that she left public practice to work in public health because one day

[6] From World Bank 1996:61

she found herself yelling at a woman who had come in, late, with obstructed labour. "You know," she told me, "that's when I realised I couldn't do this anymore. I was so frustrated, so angry, that I was yelling at these poor patients." The dire situation of the public health system, she felt, compromised her political ideals about access to health care.

Private health care

The poor cannot afford the public system, and the wealthy can pay for better care. As a result, in the city, the private biomedical system does a brisk business. Private *cliniques* abound. These are small hospitals, with basic outpatient and inpatient services. The larger ones have a fuller range of services available, including radiology and even CT scanners. They are run on a for-profit basis, and compete aggressively with each other for paying patients. Although they are required to have a license to operate, they are essentially unregulated.

By law, private companies have been obliged, since the colonial period, to furnish "occupational health" services to their workers. Companies comply by offering some preventive health services to their workers: a medical exam when they are hired and periodic health exams. This is the strict minimum, and is usually dispensed through an on-site department (*médecine du travail*). The philosophy behind *médecine du travail* is a legacy from colonial times, when biomedicine was seen as an important management tool for maintaining a productive African labour force.

This view evolved through decolonisation, as biomedicine played an increasingly important role in managing industrial relations. In colonial times, French staff had health insurance and access to the colonial health service (Domergues 1986). With Independence, this translated into health insurance that was extended to African executives and, gradually, to office workers and even foremen[7]. By doing this, the private sector followed the lead of the public sector that entitled, as described above, its workers to modern health care.

[7] The systematic reference to a quadripartite division of the workforce into *cadres*, *employés*, *agents de maîtrise* and *ouvriers* — executives, office workers, technical supervisors or foremen, and labourers — is another colonial heritage.

While some companies do not insure their workers, they do provide access to free consultations in the company dispensary. In addition, a few companies offer subsidised or even free medicines. Companies that do not allow workers to get medicines for free usually allow workers to borrow against their salary in order to purchase medication. This leads to significant losses, as some patients end up owing so much money to their employer that they are required to work without pay for months. As a result, many leave and go work elsewhere once the debts have piled up. Companies also lose money in the case of chronic illnesses that prevent employees from working. This is a growing problem as the impact of the AIDS epidemic begins to register.

Health insurance

As a result of the problems, some companies opt for health insurance, reasoning that co-payment by workers would stem the financial losses of the occupational health services. However, health insurance stimulates consumption of biomedical services by workers, who reason that they are entitled to health care that they have paid for. Health insurance plans run a perpetual deficit and companies recover their losses by increasing premiums. Employers pass on the cost of increased premiums to workers by increasing their health contributions the following year. This creates a vicious cycle, as workers believe themselves entitled to consume more health care. I was given access to private health insurance data that consistently showed that, counter to prevailing conceptions, consumption of health care is proportional to rank — *cadres* consume the most, and *ouvriers* the least. Thus, the strategy of extending more generous coverage to executives and office workers only contributes to increasing costs.

The problem of the expense of health care is exacerbated by physicians' prescribing practices. Prescription of multiple drugs is the rule, fuelled by the public's perception that more drugs are more effective, and that a large number of drugs prescribed is evidence of an astute clinician. In some cases, physicians are also encouraged to prescribe more medications because of a discrete system of kickbacks from pharmacies. Ironically, this often leads to inadequate treatment, as patients either do not have enough money to pay for the entire prescription or, if

they have been able to raise the money from their employer or their family, prefer to pay for one or two drugs, and pocket the difference. Drug selection, most often, is made by patients themselves or occasionally by untrained workers who staff pharmacy counters.

Health insurance thus encourages the inflation of costs as providers can make more money by prescribing more care, and patients, believing that more care means better health, are only too willing to oblige. It is, as the American saying goes, a "bad case of good insurance." In a market where more and more health professionals are chasing after fewer and fewer patients able to pay, the incentive is to boost income by performing as many diagnostic and therapeutic interventions as possible.

Despite the "headache" health insurance represents, insurance companies are obliged to offer it to corporate clients as part of a general insurance package (against fire, theft and so on) as a way of keeping their business for the more lucrative overall insurance contracts that earn them profits. This provides a golden opportunity for managed care firms. By offering to control costs, they promise to relieve a major headache for both employers (that need to control costs while still offering some kind of health insurance to their workers to maintain labour peace) and insurance companies (that did not have the time or the motivation to manage health portfolios). Managed care burst on the scene with a vengeance in 1998, in the form of an upstart firm owned by a Malaysian holding group. Run by a maverick businessman, the firm's ace in the hole was a sophisticated database that was able to track beneficiary health expenditures.

Within a year, the company was managing health care insurance for over half of the 300,000 insured in Côte-d'Ivoire. The company used its market clout to drive down prices, pitching it into an all-out war against physicians and clinic owners. The conflict was particularly bitter, as the managed care company's founder "clearly had a chip on his shoulder" and was "out to get physicians," according to his staff. He used his database to weed out fraud and drive down prices by making practitioners compete against each other. This businessman told me that substantial political interests had been marshalled against him and that he had received death threats. "Private clinics," he told me, " are machines for putting money into doctors' pockets." His contempt for "professors who spend their time

going to colloquia and drive around in big cars" was only matched by the near evangelical zeal with which he believed that his health care model would improve quality and drive down prices so that even poor Abidjanais could get medical care.

This insurance entrepreneur told me that he had calculated he could turn a profit by charging 1000 CFA for a single consultation, only double the rate nurses charge in the informal health sector, and one tenth of what private physicians charge. He enjoyed telling me stories to illustrate how physicians were so blinded by greed that he could easily dupe and manipulate them into accepting his terms for health maintenance contracts. Billing fraud was commonplace he told me, including operations performed on corpses for billing reasons. I was in fact able to verify one of these claims. (For large claims, inspectors from the HMO visit to ascertain the legitimacy of the billings submitted by the clinic.)

This man's evangelical zeal served the company well, as it is a useful skill in winning over managers and workers to his model of managed care. Workers are understandably suspicious that any switch to a new health care plan will entail loss of benefits, but are swayed by his fiery rhetoric and unusually frank talk. Managers are won over by the greater certainty afforded by the computerised database that makes them feel they can have more control over costs while not sacrificing labour peace. Within a year, the company was busy turning itself into a health maintenance organisation, building its own clinics and hospitals, in order to have a firmer control on costs and be less dependent on private clinics.

This shift also reflects the difficulty of sustaining health insurance schemes in a social and biological environment where acute, life-threatening diseases are common. It is worth recalling that, unlike airplane crashes, the birth of twins, or lunar eclipses, illness in a developing country is a frequent event. Illnesses are usually of infectious origin and, unlike the vast majority of infectious diseases in northern countries, potentially fatal. For instance, by far the most common diagnosis in biomedical practice in Abidjan is malaria, a potentially fatal illness.

Insurance is the pooling of risk across a population. This allows a large group to share the cost of rare — and expensive — mishaps. The possibility of insurance requires the ability to predict mishaps or unfortunate events that occur randomly.

Statistics allows the reliable prediction of random events occurring within a group, but only if these are pooled across a large enough population[8]. Insurance does not work for common mishaps, as it does not work to decrease exposure to risk. In purely mechanical terms, the only way to turn a profit on health insurance was to centralise the market and cut costs, rather than improve risk management.

As a collective response to managing misfortune, insurance requires a social infrastructure to stabilise and enumerate populations. In French social thought, this infrastructure is conceptualised as "solidarity" (Durkheim 1985). Empirical research has shown that solidarity was enmeshed in the process of nineteenth century nation-building, what Foucault has termed as the operation of "bio-power" (Foucault 1986, Ewald 1996). The health seeking behaviour of insured workers illustrates one of the consequences of biomedical modernism in Côte-d'Ivoire: health is perceived as a commodity, to be purchased in the form of biomedicines, rather than as a misfortune that can be managed through collective solidarity. Collective solidarity does exist, however, but in the form of the kinship ties that are mobilised in times of illness to obtain the resources to purchase biomedicine. The lack of a national health care system is the lack of an effective form of solidarity. As a result, attempts to manage health are always caught between individualised forms of health care consumption and kinship-mediated collective responses to affliction.

The informal biomedical economy

The tension between individualised health seeking behaviour and patterns of resort constrained by kinship relations is also visible in the informal biomedical economy. By the time the health care sector was liberalised, consumption of patented medicines was firmly established as part of the patterns of resort of *Abidjanais*. Pharmaceutical brand names are aggressively marketed on billboards and pharmacy windows throughout the city, often displaying healthy, middle-class Africans in settings that look more European than African. (Advertisements

[8] For example, if one in a million pigs can fly, this does not allow me to know with certainty whether *my* pig can fly. However, if I have a million pigs, I can be sure that one of them will fly the coop, so to speak. Since I do not own a million pigs, I can purchase insurance against pigs flying away from an insurance company that can, by insuring a million pig owners, reliably know how much flying pigs will cost.

for toothpaste, or bouillon cubes do likewise.) This undoubtedly contributes to Côte-d'Ivoire's leading national market share for pharmaceuticals in sub-Saharan Africa.

Brand-name pharmaceuticals are important social signifiers — they sign modernity but, more significantly, status. In a country where illness is common, expensive medicines are among the cheapest of expensive status symbols. Few can afford a car, and everyone can afford cigarettes and even nice clothes. Medicines are in a price range that allows even the not so well off to signal that they are not poor; that they are able to take good care of themselves. Unlike jeans or sunglasses, there are few pharmaceutical knock-offs because the generics market is still small. The impact of pharmaceutical consumption practices is acutely felt by the third party payer agencies that must reimburse the cost of medicines. As one manager told me, "when *Madame* alights from the bus with her little pharmacy bag, the whole neighbourhood gets talking."

With liberalisation, licensed pharmacies proliferated across the city — over 150 were counted in 1995. In poorer neighbourhoods, pharmacies are often the only "modern" businesses, located in imposing buildings that quickly become local landmarks and figure in *gbaka* destination calls (chapter 5). The absence of physicians creates a niche for dispensaries, but these were few and far between. As a result, unregulated infirmaries and drug sellers also proliferate, leading to a significant informal market in pharmaceuticals and biomedical interventions.

While a significant minority of *Abidjanais* access private biomedical care, most care-seeking occurs in the informal sector. This includes resort to traditional healers and other medical traditions but for the majority involves *ad hoc* consumption of pharmaceuticals. Partial adherence to prescribed drugs is common for economic reasons, as is the practice of obtaining drugs from pharmacies usually through untrained assistants, or obtaining drugs from resellers who sell biomedicines in the street or in markets. (As discussed above, the economic and cultural incentives to supply prescriptions of multiple drugs by physicians may not be a particularly rational practice.) Significantly, even in the informal sector biomedicine is the dominant medical system.

The three major elements of the informal biomedical economy are infirmaries, injectionists, and unregulated lay pharmacists. Private infirmaries proliferated after the economic crisis, and are now a fixture in Abidjan's sprawling townships. They are unregulated, although most are staffed by qualified nurses who either cannot find employment in the formal biomedical sector, or set up their own business to gain extra income. Consultation fees are a fraction of what they are in the formal sector — the average is 500 CFA (roughly $1) compared to 2 000 to 10 000 CFA in the formal sector. Most Abidjanais do not notice the difference between nurses, who prescribe, and physicians. In addition to providing prescriptions, infirmaries also perform basic nursing acts such as stitching wounds, setting up drips, and giving injections. However, Injectionists, perform injections for patients who have already purchased injectable medicines. The most common injections that people self-medicate with are quinine for malaria and various antibiotics.

For the majority of Ivoirians, the absence of health insurance means that they cannot afford prescription drugs. As a result, they must raise the money to pay for medicines by asking relatives to help. How much money they are able to mobilise from these kin networks depends on a complex entanglement of factors: their social position within the family, the assiduity with which social relations have been cultivated, and the influence wielded by their advocates within their family. "African solidarity," as most locals call these kin-derived forms of solidarity, means that it is difficult for family members to refuse without fearing a dangerous degradation of their reputation should they ever be in a position of need. "African solidarity" is occasionally exploited for financial gain because individuals may use prescriptions to raise money but do not purchase all the medicines prescribed.

The picture is one of a profoundly irrational modernist health care sector. Public health has been hollowed out, as gleaming hospitals stand empty. Basic primary care is a shambles, and consultation fees in the public hospitals where the infrastructure is poor are now the same as in the private sector. Meanwhile, an intensely competitive private market has emerged. The commodification of biomedicine results in complicated entanglements with local, kinship-derived forms of therapeutic solidarity. The impact of biomedical hegemony and of the hybridisation of biomedicine with African solidarity is visible in the non-

biomedical sectors of the informal health economy, as will be shown in the discussion below.

Therapeutic modernism outside biomedicine

Evidence of the modernism of the therapeutic culture in Abidjan is not limited to expenditure patterns. Take the case, for example, of the *Ministère spirituel des Soldats de Dieu pour la Délivrance du Monde et l'Unification des Églises* (MSSD-DMUE), headquartered at the corner of *avenue 18* and *rue 23*, in Treichville. I was led to the Ministry by the precise directions and an eloquent description contained in a *mémoire* on the subject of religion and AIDS in Abidjan (Péducasse 1996). The Ministry was founded in 1983, by Alouhoussène Fadiga, Lord Canon of God, and his two sisters, Fatou Fadiga épouse Lavri and M'Mah Monique Fadiga, Fatou's junior. After his death in 1993, the senior sister, known as the Queen of Mothers, took over the reigns of the Ministry, offering spiritual guidance to the Soldiers in Treichville and other townships of the city through her cell phone from her comfortable, but not opulent, villa, in the middle class suburb of Riviera, not far from current President Laurent Gbagbo's house. On the other end of the line was, most often, Assistant Kouadio Kouassi who relayed instructions to the Soldiers.

I had the pleasure of several wide-ranging and rambling interviews with the matronly Queen of Mothers in the Riviera house that, she confided in me, she had designed since she "dabbles in architecture." These meetings were interspersed with phone calls where brisk and quasi-mystical advice was dispatched: "there are negative vibrations happening there — you must be careful!" Or, "this is clearly the work of the Devil! You must be firm." The Queen of Mother's biography is unremarkable — daughter of a Muslim Guinean father "of the Susu tribe" and a Catholic Ivoirian mother "of the Appolo tribe," she was raised Catholic and married and divorced twice "because they wanted to convert me to Islam." She has two boys and seven girls, and worked for many years as an Administrative Secretary in the *Direction Générale des Grand Travaux*, the Ministry charged with supervising large infrastructural projects. Reports of miraculous cures from AIDS were pulled out, although the Queen of Mothers was more concerned with the everyday afflictions of her charges that she, like many of her medical colleagues,

attributed to constipation because of a diet overly rich in palm butter and cassava. Our series of interviews were unfortunately cut short by the events of Christmas 1999[9]. Nonetheless, we discussed future medical-spiritual collaborations, and in an ongoing correspondence she reminds me not to be shy about referring difficult cases to her, and that in this age of telecommunications one can always do these things easily over the phone.

One of the Queen of Mother's important functions is as chief "auditor" of the prophecies that emanate from adepts throughout the city. The prophecies are collected in neighbourhood churches, typed, carefully entered into ledger books, and forwarded to the Riviera house for verification. Once this done, they are dated, stamped and neatly filed in the Treichville headquarters. The Ministry is hierarchically structured, with the city divided into continents that correspond to townships — Yopougon and Adjamé, to the west, are Asia; Koumassi, Treichville and Marcory make up Oceania; Adjouffou and Port-Bouët are Europe; Abobo and Cocody comprise America; and the interior of the country is mapped as Africa. Each continent is presided over by a Governor and his Assistant, and a panoply of "technical commissions" that attend to questions of "economics," "accounting," "literature," "sectoral projects," "medical and social issues," and "information systems."

A concern for proper organisation is reflected in the Treichville centre. Forms recording services, number of attendees, and prophecies, are carefully tabulated and stacked into neat piles. This bureaucratic office is separated from the maiin entrance where one enters for spiritual consultations. For these, one enters through a small hall where young Soldiers are milling, before arriving in a *cours* filled with benches. All around, Soldiers pray loudly, murmuring, chanting, and hissing. Péducasse describes undergoing a session of "laying on of hands" during which six women prayed over her while massaging her legs, her arms, and her thighs. I had brought the *mémoire* with me as a token of introduction, and having read it while waiting for the bus, was disappointed that nothing of the sort

[9] In fact, it was when I called her to confirm an appointment that I first found out the events were happening. She told me not to come as "*les voies sont perturbées*," an expression I initially took to mean that her spiritual lines of communication were inoperative before I realised the static on the line was the gunfire and shelling that announced the beginning of the mutiny that led to the overthrow of President Bédié the next day.

seemed to be happening while I was there. However, I was escorted to meet one of the Elders in the consultation room, a small dark room off the courtyard lit only by natural light that falls in through a slatted window. The Elder sat in a large padded armchair with her back to the door. Across from her was a worn couch where consultations take place.

> Into the consultation room with Elder Élisabeth. She tells me that "you are tired" and that I "like to do social work" and that is why. We discuss. She looks at me intensely from her chair. Coming into the room, she is always sitting there, her back to the door, head slightly cocked and coiffed with a knitted wool bonnet, looking ahead. It's a bit like being brought into the realm of her gaze for scrutiny — discernment. I feel oddly like I am about to begin a psychoanalysis session.
>
> Fieldnotes, 27 August 1999

In my conversation with Elder Élisabeth, I was eventually able to get some information about her:

> She gives me the names of the ministries, we chat a bit about the church. I ask her how she came to be what she is today. Says she came to the church in 1986, she was looking for work, she's a secretary by profession, and that she came to the church because her search wasn't yielding any results. Her gifts — of prophecy, of discernment — were revealed to her gradually, and she has been where she is now since 1993. She told me of the dream where her gift of discernment was revealed — she was in a hospital, in a white gown, and a white woman in a white gown came to her, and took her dossier, and turned around. It was *la reine des mères* ("our President") who interpreted the dream, and said that it was a signal that the Lord had called her to him. She has nine children, her husband died — was called back to God — in 1996. She is "full-time", while others — including the other Elder who has the gift of discernment — is "part-time", because she works in the civil service. She lives in Port-Bouët, from where she takes the bus everyday to come to "work."
>
> Fieldnotes, 27 August 1999

Subsequent to the "discernment," consultants proceed to another room for the "exhortation," a séance of bible reading where the spirits are exhorted to come and heal the sufferer. Most consultants, Elder Élisabeth told me, come because they are poor and "don't know where to turn." They know the Ministry is occasionally able to help out with a bag of rice purchased with donations from

church-goers. The Soldiers that populate the Centre are fed lunch every day — a certain incentive to staying with the Ministry.

The Ministry, like many churches, offers a limited social security net to its adepts. Minimal needs may be meet in times of crisis, and for those with gifts — of "discernment," for instance — can aspire to a more secure position within the Ministry. What is striking about the Ministry, which enacts a classic model of religious solidarity, is its use of the idioms of clinical modernity, of NGOs, and of globalisation to organise and express that solidarity. Practices such as these are evidence, I argue, of the power of biomedical modernism to organise representations of solidarity.

Therapeutic modernity and therapeutic modernism

Just as we may speak of a social modernity, characterised by well functioning institutions and of individualisation, we can therefore speak of a *therapeutic modernity*, one characterised as noted above by (i) the rational organisation of biomedicine (ii) individualised patterns of resort and (iii) socially guaranteed access to health care. In the absence of such a therapeutic modernity, what drives the resort to biomedicine? Why do even the poor in poor countries regularly spend an enormous proportion of their incomes on expensive, at times difficult-to-obtain, western medicines? The answer is largely historical and empirical. Biomedicine is most visibly effective for acute illnesses where the consequences can be dramatic, or the effects remain visible for years after, as is the case with infectious diseases that are potentially fatal if untreated, such as malaria, or orthopaedics and ophthalmology. These happen to be illnesses whose burden is disproportionately borne by developing countries. As a result, the high value placed on biomedicine in these countries appears to be entirely rational. Yet it is in these countries that biomedicine is by far the most expensive form of therapy available. A common consequence of this is that biomedicine is often the therapy of last resort, consulted only when cheaper alternatives have been exhausted. This delayed pattern of resort means patients come to biomedical practitioners sicker, and more difficult to treat — and that biomedicine is less likely to succeed. But biomedicine is still highly sought-after, because in environments where illness and death are common, what often counts is to have given various treatment

options a chance to work. In that sense, late resort to biomedicine is good enough.

Not surprisingly, part of biomedicine's efficacy is associated with the visible elements that distinguish it from traditional medical practices. Often, these elements are not those that, to the medical mind, are actually therapeutically active. For example, the widely known preference for injections over tablets stems from the fact that many medicines were initially only available as injectables and that, in patients who are too ill to take tablets, injectables are still often preferred. In these ill patients, therapeutic success is more dramatic than in less ill patients who may have been treated with tablets. Thus, injections are credited with achieving the surplus therapeutic effect observed over tablets, even though they are biologically inert. It is of course not only needles that signify biomedicine's modernity: the reliance on imaging machines, written reports, even the uniforms — crisp white coats — are all markers of the new therapeutic order that biomedicine promises[10].

The high demand for biomedical treatments means that, even in poor countries, large sums of money can be spent on them. Even though individuals may be poor, they are able to mobilise significant amounts of capital through kinship networks and other 'traditional' forms of solidarity. Therefore, in a therapeutic economy characterised by competing medical systems and a lack of regulation, the temptation is strong to charge as much as the market will bear while at the same time cutting corners. As a result, needles may be re-used, inappropriate medicines prescribed by untrained practitioners, or suboptimal doses used. These practices follow a signifying logic, whereby the therapeutic efficacy of practices stems from their ability to symbolise, or stand for, biomedical modernity, rather than as a result of their ability to bring about specific results. This is not to deny that some symbols or symbolic practices are indeed imbued with real-world efficacy; such phenomena are widely acknowledged under the label of the placebo effect which is indeed real. Highlighting this symbolic explanation for therapeutic practices is intended to explain why certain modern-appearing practices may be preferred over more traditional ones, even in the absence of any evidence of

[10] This is attested to by an extensive literature on healing cults in Africa that emphasise the reliance on such symbolic expressions of biomedical power, for example, Willis 1968.

improved therapeutic efficacy. The result might be called *therapeutic modernism*: the application of a modernist *aesthetic* to therapy, rather than the modernist forms of social relations and calculations of means-to-ends characteristic of therapeutic modernity.

Therapeutic modernism and the HIV epidemic: two mechanisms

Returning to the central question of why Abidjan became the epicentre of the HIV epidemic in West Africa, it can be recalled that the previous chapter implicates the city's modernist culture and the emergence there of a sexual modernity. This made sexuality increasingly permeable to economic relations in the postcolonial era, and, in the context of growing inequality within and across social worlds, can explain qualitative changes in sexual behaviour that resulted in different patterns of sexual networking that increased the likelihood of sex across, rather than within, social groups.

The other piece of the puzzle lies in the therapeutic modernism of the city that has been discussed above. Specifically, I refer to the emergence of a vast informal economy in biomedicines in a context where resort to biomedicine is the norm. The contribution of therapeutic modernism to the spread of HIV is, first of all, suggested by timing. The rise of the informal biomedical economy is coincident with the years where the HIV epidemic exploded in Abidjan[11]. Therapeutic modernism contributed to the spread of HIV through two pathways: undertreatment of sexually transmitted infections and re-use of needles. These pathways, and the evidence incriminating them, are explored below.

Undertreatment of sexually transmitted infections

First, saturation and inaccessibility of public health facilities led to increasing resort to the informal economy for the treatment of symptoms due to sexually

[11] Recall that HIV became the leading cause of death of young men in 1989, and that a retrospective serological survey detected no cases prior to 1986 in Burkina Faso.

transmitted infections. Antibiotics, purchased either directly — without a prescription — from pharmacies or from street and market resellers, led to undertreatment of sexually transmitted infections. Undertreatment has two significant consequences. First, while it often relieves symptoms — such as burning urine or discharge — it does not eradicate the infection, which persists in a chronic form. As discussed in chapter 1, sexually transmitted infections greatly increase the risk of HIV transmission and appear to be enough to explain substantial differences in the proportions of epidemics in different areas. Secondly, it results in resistant organisms that can then be transmitted and making it more likely that subsequent infections will persist in chronic form.

I was able to find some evidence to support this hypothesis. Professor Mireille Dosso, microbiologist and Director of the Institut Pasteur of the Cocody Hospital told me, whereas they saw several cases a day throughout the 1970s, "we stopped seeing acute urethritides in the 1980s." Dosso's observation was confirmed by other clinicians I interviewed. All attribute it to patients not wanting to pay consultation fees, getting antibiotics off the street, or from the new pharmacies that proliferated at the period. This is attested to by unpublished data that shows a quasi-disappearance of congenital syphilis in the 1980s, suggesting widespread use of penicillin. Dosso told me once of going to pick up some medicines at her local pharmacy and overhearing a client next to her say "Excuse me, could I have more of that stuff you gave me last week, it's dripping again."

Were chronic sexually transmitted infections prevalent? While no studies addressing this problem specifically were conducted, some indication can be gleaned from a perusal of theses at the Faculty of Medicine of Abidjan. Significantly, several studies described extraordinarily high rates of sexually transmitted infections in patients consulting for infertility. In other words, these are patients whose only symptom of having an STI is infertility. These studies are summarized below:

Table 7.2 Rates of sexually transmitted infections in patients consulting for infertility

Author	Year	Study population	Diagnosis	Rate reported
Baroud	1984	258 men consulting for infertility	history of past urethritis	90%
Badreddin	1994	34 men found to have oligoasthenospermia	leucospermia bacteria in sperm	88% 52%
Kouoh	1995	67 men consulting for infertility	history of past STI STI by microscopy by culture	79% 66% 58%

The epidemiological shift from acute, to chronic, sexually transmitted infections would have had a significant impact on HIV transmission, particularly since asymptomatic STI sufferers would not have had any "signal" that anything was wrong and would, as a result, not been less likely to modify their sexual behaviour.

Re-used needles

Once again, the evidence for or against the hypothesis that undertreatment of STIs contributed to spread the epidemic remains patchy, as no epidemiological studies have been designed or carried out to test this hypothesis. As discussed in chapter 1, prostitution and migration have been invoked as "triggering" the epidemic in Abidjan. However it is difficult to attribute this as a "cause" of the epidemic as prostitutes will be present where any increase in seroprevalence "registers" first, because they are sexually exposed to a broader range of the population than most women. Of course, no comparative studies of highly sexually active men have been conducted, other than those attending STI clinics. Not surprisingly, high seroprevalence rates were detected amongst these men — but how representative are they of the general population?

The potential for re-used needles to spread and amplify HIV epidemics is well known, and has emerged as one hypothesis for the origins of the epidemic (chapter 1). In the case of the Abidjan epidemic, could the proportions of this epidemic be explained by re-use of needles? This is certainly plausible, as the growth of for-profit neighbourhood dispensaries and injectionists mushroomed throughout the 1980s. This was fuelled by decreased access to health care as has already been discussed, but also by the growing number of health care

professionals who were unable to find employment in the public sector which, with structural adjustment, was no longer hiring new staff.

Interviews with health care professionals and staff that I conducted through 1999 indicated that re-use of needles was common throughout these dispensaries through the 1980s and even in public hospitals, although no one was willing to go on record stating this — for obvious reasons. The hypothesis has never been seriously examined by epidemiologists, although clinicians I spoke to gave it credence. They pointed out, however, that they think that most of the current cases of HIV are due to sexual transmission. However, as discussed in chapter 1, a small epidemic of re-used needle-spread HIV might have been enough to trigger a wider, sexually transmitted epidemic.

An intriguing study conducted in 1995 measured seroprevalence for Hepatitis C amongst patients suffering from sickle cell disease who were treated at the Immunology and Haematology Service of the Cocody Hospital. Patients with sickle cell anaemia often receive transfusions, and Hepatitis C is a blood borne disease largely spread through shared needles and transfusions. As a result, the study was carried out to determine the rate of HCV infection in this population. The author found no difference in the rate of HCV between transfused and non transfused patients:

Table 7.4 • Prevalence of Hepatitis C in sickle cell patients

	HCV+	HCV-
Transfused n=101	11	90
Never transfused n=50	5	40

(Loba 1995)

However, of the 5 never transfused HCV+ patients, 4 had a history of having received injection treatments while only one reported never having received injections. As HCV is only very rarely acquired through sexual transmission, this suggests that HCV was being transmitted by unsafe injection practices, supporting the hypothesis that these practices could have spread HIV.

Conclusion

Biomedical hegemony over patterns of resort has its roots in colonial biomedicine as well as in the postcolonial project of building a modern health care system. However, this was not economically sustainable, particularly in the context of the economic crisis of the 1980s and subsequent structural adjusment. As a result, the public health care system is in shambles, and beyond the economic reach of most Ivoirians. The private health care system has been unable to respond to the health needs of the poor, and has fuelled a competitive marked centred on the consumption of patented pharmaceuticals. Attempts to set up private health insurance highlight the paradox of "insuring" against common misfortunes in a setting where health is commodified and, in the absence of universal health insurance, kinship is the primary form of insurance against illness. Nonetheless, biomedical modernism is a powerful idiom of solidarity, as shown in the manner in which healing churches draw on idioms of modernist organisation to organise relations of solidarity.

The impact results in a therapeutic modernism that conditions patterns of resort and an irrational consumption of biomedicines. These practices would explain anecdotal observations of an epidemic of undertreated sexually transmitted infections and unsafe injections in the informal health care sector — both are factors that would explain why Abidjan emerged as the epicentre of the epidemic in West Africa.

Chapter 8
Ties that Might Heal: testimonials, solidarity and the moral economy of disclosure

Introduction

Epidemics do not occur in a vacuum. Social relations furnish the pathways through which pathogens may circulate and trigger epidemics. The "social" quality of these relations is particularly manifest when the pathogen is transmitted through sex and other forms of highly individualised behaviour, but pathogens that are air, water, or food-borne are equally dependent on social relations. Their effects are reflected in more anonymous practices — crowded housing, water treatment, and food production — that condition their spread. As the previous chapters have shown, social change furnishes an analytic Archimedean point that allows a symmetrical understanding of how both biology and culture may co-vary. For instance, colonial representations of epidemic diseases — whether "scientific" or not — informed segregationist urban planning. By consigning Africans to insalubrious townships, Europeans made real their representations of "diseased natives." Biology and culture are both "real," material phenomena, legible in bodily states, bodily practices, artefacts, and texts. Representations are inherently social phenomena that, as the case of Abidjan's urban planning showed, allow traffic between biological and cultural changes that have very real effects.

However, the intention is not to advance a unilinear model whereby social change drives biological change. The relationship is two-way: biological change may also drive social change. The following chapters will consider how this occurs, but first I will focus on the discursive and material dimensions of social change before turning to the biological dimension. I will start out with an examination of how social relations changed directly as a result of discourses about AIDS brought to Côte-d'Ivoire by transnational institutions and development agencies. Collective responses to the HIV/AIDS epidemic that came about in Burkina Faso and Côte-d'Ivoire in the late 1990s are the focus of my attention. Drawing on ethnographic data collected on community groups that organised around the epidemic during this period, this chapter explores how illness narratives about being HIV positive and associated practices of disclosure shape the social ties that bind individuals together in these community groups. While the notion of a therapeutic community organised around a shared disease entity is an alien one, imported by development agencies and AIDS activists to Africa in their attempts to catalyse a response to the epidemic, these new social ties draw on local understandings of kinship relations. It will be shown that these ties are neither substitutes for kinship relations, nor are they completely devoid of the everyday realities and practices that come with kinship. Kinship, I argue, is the idiom through which new forms of relationships, and indeed solidarity, are explored and worked *at* as well as worked *on*. As we shall see in this account, these relationships are always a work in progress.

The evidence produced below suggests that such ties cannot be understood as the product of either institutions or experience; rather, they are the result of a diverse array of practices (testimonials, narratives) that are mobilised by actors across varied landscapes of constraint. The solidarity that results is a precarious and constrained one, limited to small groups of individuals scattered across the Third World. And the apparatus that has made this possible is a diffuse one, a loose coalition of actors embedded within a broader humanitarian apparatus that has proliferated on the margins — rather than at the core — of the nation-state. As a result, I suggest that the NGO strategies discussed below offer evidence of new humanitarian configurations of the way in which people fashion themselves into subjects of government — what Foucault has called governmentality (Foucault 1997).

In this particular instance, these configurations are not the result of a state apparatus that assigns citizen-subjects identities, careers, and choices. Rather, these configurations are produced by a diverse array of institutions and actors has come together to address the AIDS epidemic world-wide. This transnational coalition groups together development agencies, northern and southern nongovernmental organisations (NGOs), pharmaceuticals firms, AIDS activists, religious groups and therapeutic entrepreneurs of all sorts. This coalition shares biomedical ideas about HIV and AIDS.

Jeunes sans frontières: from voluntary association to testimonial giving

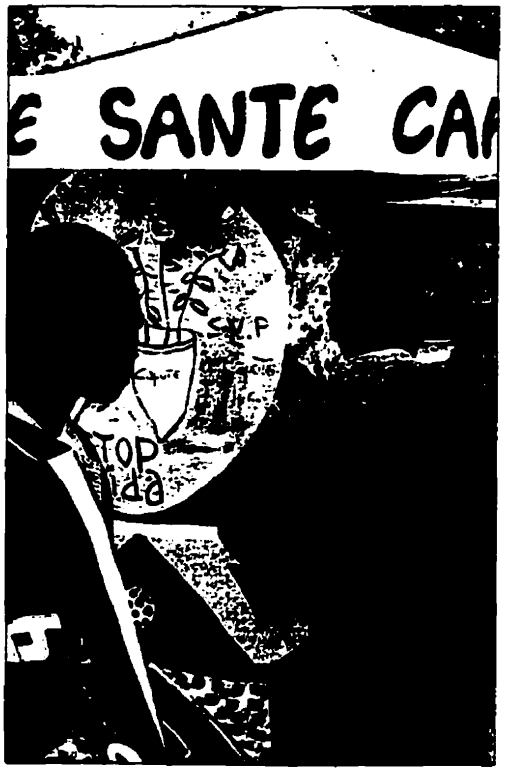

Figure 8.1 • One of *Jeunes sans frontières*'s kiosks.

The story of *Jeunes sans frontières* is in many ways typical of community organisations that have come to be at the forefront of the fight against the AIDS epidemic in Africa. Like many of these organisations, its initial involvement in the epidemic was an accident of circumstance, a case of being at the right place at the

right time. Once involved, things took on a dynamic of their own, in the way one might accidentally get on a path and then find it very difficult to change directions. *Jeunes sans frontières* defines an intermediary space between that of local, kinship-based forms of social relations, and the transnational strategies of development agencies. At this intersection, local actors work hard at translating this trans-national agenda into locally meaningful and practical outcomes: material resources, new social relations that can be counted on in extraordinary times, access to effective biomedical treatment. Given their activities, the story of *Jeunes sans frontières* recalls the "voluntary associations" described in the anthropological and historical literature on urbanisation in colonial Africa[1]. Unfortunately, from this literature it is difficult to get a sense of who those local actors were, and by extension of how the work they did manifested their agency in the face of colonial administration. As we shall see here, the agency of local actors — such as the members of *Jeunes sans frontières* — is real, but nonetheless negotiated within trans-national strategies characterised by marked asymmetries of power.

It is common to attribute the success — and occasional demise — of such organisations to a charismatic founder, and certainly *Jeunes sans frontières* would seem not to be an exception. Its founder, Abdoulaye Ouédraogo, although soft-spoken, is clearly known as the group's leader, although this might not appear evident from his shy, retiring manner and tendency to speak softly using a self-effacing third person. For those around him, Abdoulaye is different from others his age — his uncles treat him almost as an equal, according him more respect than those in his age-class and even than his older brother. That this has not caused any tension is evidence of Abdoulaye's skill at balancing the needs of family hierarchy with his own projects. Neither he, nor his cousins and friends, attribute this to his personality — for them, it comes from his being a "diaspo," a burkinabè born south of the border in Abidjan, who is wise in the ways of the fast life in the big city. Not that he is viewed as somehow "denatured" by his foreign experience — a burkinabè always remembers his origins, I was often told. When he returned to Ouagadougou in Burkina Faso in 1990 to pursue his studies, he was returning home although he had never lived there before.

[1] See, for example, Banton 1965, Deville-Danthu 1992, Little 1962.

Abdoulaye's parents had moved to Abidjan for work in the sixties, when the Ivoirian economic "miracle," fuelled by favourable global market prices for the country's primary exports of cocoa and coffee, was still in full swing. Abdoulaye's parents found work in the booming economy: his mother in a plastics factory, and his father at the Port, the major clearing-house along the coast for the interior and the landlocked countries of Mali, Burkina Faso and Niger to the North. In their trek south, Abdoulaye's parents had followed a well-worn path — the migration route between Burkina Faso and Côte-d'Ivoire dates from the earliest colonial times.

Abdoulaye grew up in the Abidjan neighbourhood of Anoumabo, formerly an Ébrié village on the lagoon which had long ago been swallowed up by the sprawl of the city and had become home to many burkinabè. His older brother stayed, their father having found him a job at the port, but Abdoulaye wanted to continue his schooling. Abdoulaye's family could not afford to keep him in school in Côte-d'Ivoire, where school fees were higher and foreigners were not eligible for the few scholarships available[2]. So, after he finished his secondary school in Abidjan, Abdoulaye returned to Ouagadougou to go to university in 1990. Once there, he moved into the family home: a cement house around a courtyard, inhabited by his father's three brothers, each with three wives, and each with "five or six" children. The family got by reasonably comfortably: although illiterate, the uncles were successful merchants, and the wives managed small businesses out of the home. They sold charcoal, fried doughnuts for sale to passers-by, and used the capital they accumulated to buy bags of rice and millet they resold in smaller parcels.

Abdoulaye spent a year at the University in Ouagadougou, but the transition was difficult. Ouagadougou was not like Abidjan, and he couldn't shake the feeling that he didn't quite belong. Perhaps this was why Abdoulaye became interested in "youth" — in the way others his age lived in Ouaga, and the problems they faced. Maybe his desire to be involved was a way to reconcile his feelings of being different. With his analytic mind and good writing skills, Abdoulaye quickly learned that he didn't need to finish university to make a niche for himself. He

[2] Fees for attending public primary and secondary schools were introduced in the 1980s throughout the developing world as a result of World Bank and IMF mandated structural readjustment programmes, which advocated cost recovery through user fees.

experimented with writing up project proposals for development agencies, and a number were funded. Ouagadougou had become a centre for these agencies for several reasons — a number of droughts had devastated the countryside, and Burkina had a reputation for being a good place to work: the people were honest, and the government was welcoming. After the crisis of the droughts of the seventies had thankfully passed, the development agencies stayed, and turned to other problems, including family planning. Abdoulaye came along when family planning had already been embraced as the solution to poverty, and attention was beginning to turn to the importance of educating young girls in the ways of family planning, particularly contraception. These interventions were the forerunners of subsequent AIDS education campaigns.

By 1995 AIDS had become of major concern for development agencies. The epidemiological statistics were worrisome — the epidemic was exploding to the South, particularly in Abidjan, and the figures from Burkina seemed to indicate that the epidemic was already firmly installed in there. It is widely believed that HIV travelled through the migratory system from Abidjan, thought to be the epicentre of the epidemic in West Africa[3], to Burkina Faso. Abdoulaye and his parents were part of the estimated 3 million Burkinabè who divide their lives between Burkina Faso and Côte-d'Ivoire[4]. While some move to Abidjan for work and then stay, or else move back to Burkina for school, the more usual pattern is for young men to leave the agriculturally desolate areas of northern Burkina Faso that are prone to drought, to work on the plantations or to work in the city (as servants, or gardeners, or "hustling" parking cars or any other of a myriad jobs in the big city's informal economy) and then to return to the village to marry once they have saved up enough money. It is this pattern that is believed to have extended the reach of the epidemic from the metropolis of Abidjan as far as the isolated villages on the edge of the Sahara, thousands of kilometres to the north.

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[3] It has been argued that Abidjan was the epicentre for the epidemic in West Africa, as during the heady days of the Ivoirian miracle new found wealth led to an explosion of sexual promiscuity (Gould 1994). This particular explanation has not been contested, but as I have shown so far is too simplistic and may, for example, discount the role of widespread transfusion practices in amplifying the epidemic in the context of Abidjan's relatively westernised medical system. But the question of where "it" started and "how" it spread obscures a more basic issue: that one of the necessary preconditions for spread to occur is not migration, but the steep gradients of social inequality that drive migration.

[4] This figure has most recently been widely cited at the time of writing with the repatriation of an estimated 9000 Burkinabè from southwestern Côte-d'Ivoire subsequent to an "ethnic conflict" in November 1999.

When I first met him in 1995, Abdoulaye had already developed an impressive list of development credentials, in the form of several projects funded and successfully carried out. By then the introductions he was writing to his project proposals were ethnographic treatises in their own right. Demographic statistics were cited effortlessly alongside observations about the sexual lives of urban youth, and incisive analyses about the cultural barriers to addressing issues of sexuality. Development agencies had been quick to respond, and had been subcontracting the organisation he founded, *Jeunes sans frontières*, to carry out family planning education campaigns since 1993. As a result, the organisation had chapters in over a dozen neighbourhoods. This had given Abdoulaye the opportunity to embellish his project proposals with the wealth of information he had gathered through his involvement in these campaigns.

For the family planning campaigns, Abdoulaye recruited articulate young people and trained them as "peer educators": youth that educate other youth about the importance of contraception. This allowed him to pay them modest fees from the contracts, and with the small overheads he earned from these he was able to rent a modest office on a busy road not far from his house. When AIDS appeared on the agenda of the development agencies in 1994, the major emphasis was on encouraging condom use — the family planning strategy Abdoulaye and the group were most familiar with.

Jeunes sans frontières' first experiences with HIV activities were the World AIDS Day events held on December 1st of each year. Abdoulaye told me these were "a blast". The National AIDS Program could be counted on to hand out small grants to do "awareness-raising" during the government organised AIDS parade, and the colourful NGO stands lent a festive air to the proceedings. There would be giveaways of T-shirts and rubbers, shows, and the obligatory displays of putting condoms onto wooden penises.

The experiences of both World AIDS Day and family planning campaigns made it easy to retool his organisation to respond to the development agencies' new priority. Abdoulaye told me he was glad he could stay in the business of educating people about sexuality — it was interesting, and he was always looking for opportunities to carry out his own research on the side. What he found out

with his research (why girls would sleep with men for money; why most of the tailors in Ouagadougou were Ghanaian) he could then use to improve on subsequent project proposals.

We often met at the *Jeunes sans frontières* office, which was both a headquarters and as a social centre. Young men and women, presumably from the group's various "antennae" (as Abdoulaye liked to call them) in the city, would drop by on errands or requesting advice, more often than not lingering, the women chatting outside or the young men draping themselves over the three rickety chairs grouped around a table. Gradually I would learn that most of these young people, the inner circle of the organisation, were either relatives of Abdoulaye's — cousins, brothers, sisters — or young people he had befriended and who had, as a result, become like family, a few of them even moving into the family compound. The office was equipped with a typewriter and a shelf stacked with glossy family planning brochures and decorated by three AIDS posters: from Uganda (a photo of a gaunt man with his two children on a bench and below, in English "I had lost hope. You counselled me. TASO - The AIDS Support organisation"), Côte-d'Ivoire (a dying man on a cot in a hospital, his eyes blanked out with a black rectangle: "I have AIDS. Don't abandon me. National AIDS Control Programme") and America: an incongruously colourful picture of the virus and its genetic components.

Lit by a naked light bulb, the office still appeared dark with its green walls, and the ceiling fan always seemed ineffective against both the heat and the dust on the brochures. At the time, the images on these posters were a distant reality for Abdoulaye. He knew the figures for Burkina — 10% of the population had been estimated to have been contaminated by HIV — but he had never met anyone who was HIV positive. He believed the problem was there — he knew that most youth didn't use condoms, and given the statistics, it was inevitable that the virus was spreading. In this, Abdoulaye had come to the same conclusion as the development agencies. By late 1995, the agencies were getting concerned — despite the proliferation of condom promotion campaigns, they had the nagging sensation that no one was taking the problem seriously enough. "It's all just theatre" summed up one development official — "IEC activities [Information-Education-Communication, as such condom promotion campaigns were called] won't lead to sustainable behaviour change." The proof, for the development agencies, was that no one seemed to talk about AIDS "unless they're paid to,"

there were no press articles or other manifestations of "genuine concern." The term "silent epidemic" was used interchangeably with "invisible epidemic" to describe this situation which was inevitably contrasted with the alarming figures drawn from sero-prevalence studies[5].

Both officially and off the record, the lack of "visibility" of the epidemic was decried as a major "barrier" to combating the disease, and evidence of "denial." These claims would have been bolstered by a visit to the local hospital — there, the epidemic was clearly visible to the clinically trained eye. Physicians who practiced in Burkina's public health system privately acknowledged seeing clinical cases of AIDS starting in the late eighties, but were unable to confirm their suspicions because of the lack of tests and the impression that this was not really considered important at the time.

However this clinical visibility didn't translate into the kind of visibility the development agencies wanted. Although in the early years HIV testing kits were rarely available, even when this situation changed, patients were still not told their diagnosis. Winston, a nurse in one of the main medical wards, once showed me a stack of patients charts in the small call room where he slept on night shifts. Patients who had had positive tests results had the result clearly indicated with the hospital's diagnostic code for HIV infection ("1762") on the chart: about three quarters of the patients in this ward had the number inked in red on their charts. Only a handful, though, had the letter "A" beside, which meant they had been told. He framed the reason for not informing the patients very simply. "Patients aren't told because it would only discourage them." In his experience, patients who were told went on to die very quickly. His ward is divided into two sections — one for more acute cases, and one for more chronic cases. "Once an HIV patient gets transferred to the chronic section, he realises that he has HIV even if he hasn't been told, and they rarely last more than a few days."

Abdoulaye, meanwhile, was encouraged that two of his projects, which had been funded by a European embassy and a British organisation, were underway and

[5] Such studies involved drawing blood from select groups — such as pregnant women, those seeking treatment for sexually transmitted diseases, hospital ward patients or even "high risk groups" like truck drivers — and extrapolating the observed rates of HIV infection to the general population.

seemed to be working, at least in terms of the goals he had set for them. Young women prostitutes were buying and reselling condoms he was purchasing from an American social marketing[6] program, as were the young Ghanaian barbers whom he supplied with condoms and had persuaded to use disposable razors.

The year after Abdoulaye's second World AIDS Day, in mid July 1995, he came across a letter, published in a local newspaper.

> I am a 27 year old man and I live in a neighbourhood of the capital. But I will have to leave this neighbourhood, where I have lived for 10 years, because I am singled out and my neighbours who know me well flee me. The last few months have been hell for me. Even when I feel like having a beer in the bar next door, the customers get up, quickly settle their bills, timidly say good bye to me and disappear. Others, often, buy me a beer and when I get up to shake their hands and thank them they refuse to shake my hand. It's unbearable for me — and I've done nothing wrong. I have neither stolen, nor beaten anyone, nor raped anyone. My crime is to be seropositive, and AIDS, this disease which frightens so, has terrorised my neighbourhood where I lived peacefully until everyone found out. I have lived through desparate moments. At home, when the meal is ready, no one wants to sit to eat with me. Everyone manages to eat before or after me; never at the same time. But my portion of food is always kept for me and is always generous. My mechanic refuses to fix my moped because, according to him I may have cut myself and if my blood has touched the engine, he could contaminate himself. He told this to his apprentices: "Money, sure, but my life comes first!" What is happening to me is a scandal. Those like me who have contracted this horrible disease need to communicate, to feel loved and that we are not different from others. We know that we have little time left to live; so we must not give up hope. Why make us suffer even more in our bodies, in our spirit and in our hearts?

By the time the letter was published, *Jeunes sans frontières* had multiplied its successes at fundraising, and Abdoulaye, with his youthful management team, had opened up a string of AIDS awareness cafés across the city: little kiosks, where Nescafé, soft drinks, and condoms could be purchased. The kiosks were staffed by "peer educators". That these "educators" seemed more interested in

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[6] Social marketing refers to using free market methods to distribute socially useful goods — such as condoms, oral rehydration solutions for diarrhoea, and so on — at a subsidised price. Resellers buy the goods cheaply, and make money by reselling them. Demand is spurred by marketing campaigns.

catching up on the latest political gossip with customers and selling sandwiches seemed to confirm the development agencies' worries that their prevention campaigns weren't getting very far. But for Abdoulaye this was *Jeunes sans frontières*' most practical accomplishment so far because it had been able to employ some of the young people who had been volunteering in his group, young people who would otherwise have had no source of income. As Abdoulaye pointed out, this made it significantly less likely that they would be tempted to exchange sex for money and put themselves at risk for getting HIV.

A few weeks before World AIDS Day of 1996 Abdoulaye told me about reading the letter. He had responded by writing back to the newspaper, which published his letter, offering the support of *Jeunes sans frontières* to the youngster. The young man, Issa, came to the organisation's office, and Abdoulaye eventually found him some work delivering bottles of soft drinks to the kiosks.

Abdoulaye told me his response to Issa's letter in the paper was an opportunity to respond to a situation he believed to be "real" but hadn't been able to address directly because he hadn't met anyone HIV positive until he met Issa. He pointed out that the HIV sero-prevalence figures, which he knew by heart from writing up project proposals, meant that he knew that people with HIV were "out there". And perhaps he was also curious — until he met Issa, "all this AIDS business" remained somewhat of an abstraction to him. Issa's story certainly corresponded to what Abdoulaye expected — his account of rejection and solitude echoed the posters on the walls of the office. Abdoulaye was used to dealing with young people in difficult situations — without income, living with families that couldn't afford to feed them, but Abdoulaye felt Issa needed "special" help right away because of his "situation". But how to offer that without singling Issa out? "Issa needs to talk, and one of these days he'll need medicines he won't be able to afford even with the small income we can give him" Abdoulaye told me. Issa was different in Abdoulaye's eyes because what he felt he needed — to talk about his experience of being HIV positive — couldn't be resolved by adopting Issa into the extended family, the extension of Abdoulaye's family that was *Jeunes sans frontières*.

Abdoulaye never told anyone about Issa's HIV positivity until much later. Abdoulaye confided to me about Issa, trusting me because I was an "outsider",

more specifically *un blanc* who therefore could be trusted not to tell. Abdoulaye once told me that "the African feels that he can trust the White man...because they're not like us, they don't go around telling everyone everyone's secrets." As a result, he introduced me to Issa because he felt that Issa would be able to "open up" to me about his HIV positivity. But Issa did not confide more to me than he had to Abdoulaye. For him, even though we were both trustworthy and I could offer medical reassurance, Abdoulaye had the position of a "senior brother" (even though in fact Abdoulaye was younger than Issa), because he had taken on the burden of Issa's secret and would "look after" him.

But, that November of 1996, Issa's trust in his new senior brother took on new ramifications. Abdoulaye had for some time — even before Issa's arrival — been dropping hints that there were people with HIV amongst the ranks of *Jeunes sans frontières*. He told me this was because he knew that this would give him additional legitimacy with the development agencies; and besides, given the seroprevalence rates, this had to be the case, even if he didn't know anyone who had been officially diagnosed in the group. No doubt as a result of Abdoulaye's strategic disclosures, in the weeks leading up to World AIDS Day on December 1st, he was approached by an influential member of the National AIDS Committee, who had told him that the Committee was desperately looking for someone to testify publicly on television on World AIDS Day. Since he knew some HIV positive youth, would he be able to approach them so that they could do this, "face uncovered?" Abdoulaye saw a unique opportunity: what if he could convince Issa to testify, in exchange for a commitment from the Government to supply Issa with a job and medical treatment?

The ensuing negotiations were complex. Abdoulaye didn't know whether to trust the government representatives, but didn't want to be accused of "refusing to cooperate" with them, as he needed their endorsement in order to continue receiving assistance from the agencies. And what about betraying Issa's trust in him? Issa didn't seem too concerned about this — he told Abdoulaye that he would do whatever he could to "help the association" which had helped him; after all, he had nothing to lose since he had been spurned by his own family.

Ultimately Issa appeared on television, but only the back of his head was visible. I watched the newscast with Issa, and he told me he was "shy" at the last minute,

and asked me afterwards if it was obvious that it was him being interviewed. It is unclear to this day whether Issa ever did get compensated for his appearance — he claims that he was not

A few months after first meeting Issa, Abdoulaye met a second young man, Matthieu, a burkinabè who had come from Abidjan and also said he was HIV positive. Matthieu became well known to other Ouagadougou groups that had gotten involved in AIDS activities. These groups had always eyed each other warily, perceiving themselves as competitors for the same resources, but the case of Matthieu in some ways brought them together. From their conversations, they learned that Matthieu was going from group to group, telling a story of illness and rejection and asking for assistance, a prescription in hand. Several groups gave him money to pay for the medicines. Abdoulaye started suspecting that Matthieu was an old hand at this business, and made inquiries of the AIDS groups in Abidjan who, it turned out, had had the same experience with him. The Abidjan groups eventually "smartened up" to Matthieu's strategies, refusing to give him any more money. It was after this that Matthieu showed up in Ouagadougou, where he was more successful. Abdoulaye explained to me that Matthieu had managed to get a considerable sum out of government officials ostensibly for agreeing to travel to Paris for treatment. After that, he disappeared again. It was said that Matthieu eventually ended up in prison after his disappearance, having been caught stealing. Matthieu resurfaced three years later, in 1999, embroiled in the 1998 assassination of the leading opposition journalist, Norbert Zongo. Matthieu claimed to have been hired by the government in the assassination, and then recanted at the last moment, stating that he had been paid by opposition forces to frame the President's régime. Meanwhile Issa, after another six months, dropped out of *Jeunes sans frontières*. In my last conversation with him, Issa asked whether I could help him get to Europe. Abdoulaye told me that Issa had found work, on the trains between Ouagadougou and Abidjan, transporting goats. Matthieu's story later made Abdoulaye wonder whether Issa had also gotten money from the government officials.

It took little time for Aboudoulaye to figure out Matthieu's game. Even though Matthieu came brandishing proof that he was indeed HIV-positive — a stamped, laser-printed test result from an Abidjan laboratory — his subsequent behaviour bordered too closely on the extortionary for comfort. Abdoulaye later showed me

a letter, written on personalised stationery, that identified Matthieu as a "Licentiate in Occultism and Paranormal Sciences" from the "École Supérieure de Sciences Mystiques (E.S.S.M.) de Lyon." He had found it in a pile of papers Matthieu had left at the office. Officially labelled in the African style of administrative French ("Re: greeting. Reference: 006/97/TF/RD/B"), the letter was addressed to his mother. To Abdoulaye the letterhead proved that Matthieu was an "imposter," and perhaps fed his suspicions about Issa. Yet Matthieu was not an imposter — his tangible test result and prescriptions gave him more credibility than Issa, who only had a story. It was perhaps his sheer competence at using the narrative of being HIV positive that fuelled Abdoulaye's perceptions of Matthieu's inauthenticity. More than in Ouagadougou, in Abidjan hustling is a way of life. The conjugation of the city's anonymity — where, as city dwellers often say, it often isn't possible to know "who is who and what is what" — and cheek-to-jowl rank poverty and lurid wealth seems to encourage "fast-talkin' good-lookin'" characters, get-rich-quick schemes, and improbable spiritualists. Abdoulaye knew this reality only too well, and was perhaps better equipped to decry Matthieu's tactics as a result.

The lack of clarity that surrounds both Issa and Matthieu is a symptom of how Western narratives of illness are taken up differently in a context where care-seeking is not organised by and for individuals, and where poverty is overwhelming. The AIDS testimonial is an illness narrative that can be used to gain access to resources, a valid strategy where what is always at stake is survival. Abdoulaye had become a bit of a hybrid by the time he was confronted with Matthieu — by then, he had bought into the western notions of authenticity that the testimonial implied, that one was disclosing the 'truth' about one's self. In detecting insincerity in Matthieu and doubting Issa on the basis of his subsequent behaviour, authenticity was at stake. But for Matthieu, Issa and even Abdoulaye, what was really at stake was access to material resources — money, food and medicines.

Aids testimonials: a brief genealogy

Testimonials by HIV positive people emerged as a strategic priority for international organisations' HIV/AIDS programmes in 1995. This trans-national

strategy, which created the market for testimonials that triggered Abdoulaye's dilemma with Issa before 1996 World AIDS Day, has a complex genealogy, extending back across the Atlantic and to the circumstances that led to the inextricable linkage of experience with activism by the 1990s. Here we will briefly trace this genealogy, working backwards in time.

A large proportion of those involved in the growth of the AIDS industry claim a personal experience with the illness. As a new, epidemic disease that was immediately identified with specific social groups, everywhere HIV and discrimination went hand-in-hand from the beginning. As we know, historically epidemics have been fertile terrain for exclusionary discourses and practices. Affecting groups that were already marginalised and objects of discrimination[7], HIV was a potent force bringing about stigma and exclusion. In response, a powerful activist movement emerged in the west successfully putting HIV on government agendas, and catalysed an inclusionary public health response. This historically unprecedented response was instrumental in decreasing new HIV infections and containing the epidemic in Northern countries. As a result, when development organisations realised the scope of the epidemic in the south and began to organise programmes to address it, they turned to activists to help them. Many were hired to key positions in international organisations.

These activists carried with them a baggage of beliefs and methods acquired through the gay community's engagement with the AIDS epidemic in the eighties in America and elsewhere; indeed, some of them had started out as gay activists before the urgency of the AIDS epidemic manifested itself. For others, involvement in the quasi-public sphere of the AIDS movement was a tactic for indirectly affirming their engagement with the issues of the gay movement, without necessarily publicly exposing their own sexual orientation. By the early 1990s, these professionalised activists had largely succeeded in putting AIDS on the political agenda, and in defining the terms of engagement with the epidemic, both for the State and for the biomedical industry , including health care providers, research institutions, and pharmaceuticals firms, the core elements of an emergent AIDS industry.

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[7] Initially, homosexuals, injection drug users, blood product recipients and, it was erroneously believed, Haitians.

Activists espoused a rhetoric of community development and patient empowerment that drew on a tradition that stretches backwards through the gay liberation movement of the seventies and, before it, to the women's liberation movement of the sixties: movements that originated in the English speaking world in general and the United States in particular, the legacy of which is now often referred to by the term "identity politics." This rhetoric was substantiated by evidence that the active involvement of the gay community and of people living with HIV had been instrumental in achieving public health results. Control of the epidemic in the gay community had been achieved through adapted prevention campaigns (explicit advice in bathhouses, for instance) and through treatment breakthroughs facilitated by forceful lobbying of the pharmaceuticals industry, pressure on regulatory authorities to fast-track licensing of drugs ("to get drugs into bodies") and mobilisation of patients to participate in clinical trials (Epstein 1996).

The ideology of patient empowerment was the product of diverse historical developments. Biomedicine, in the sixties and seventies, evolved into a battery of increasingly technical interventions. These had to be managed by highly differentiated specialist-experts within a health care system that had become increasingly bureaucratic as a response to the costs and complexities this technological turn engendered. In parallel with these developments, Europe and North America were swept by a diverse array of contestatory movements with roots in the American civil-rights movement that burst on the scene in the late sixties. Feminists pointed to the medicalisation of their bodies — most notably the control exerted by biomedicine over reproduction — as an intolerable manifestation of patriarchy. This radical political stance gained wide resonance throughout American society at the time: women did not have to share this political analysis to be aware of the paternalist dimension of biomedical practice.

The notions of community development and patient empowerment advocated by AIDS activism emerged from the social environment that existed at the time of the epidemic's emergence in the major cities of North America in 1981. At the time, the gay community's sense of identity was an oppositional one, strengthened by landmark events such as the Stonewall riots and by shared experiences of homophobia. In this setting, solidarity was strong and lent itself easily to the

creation of a network of community institutions. When AIDS came along, this model of gay-community self-organising was reproduced in organisations such as New York City's GMHC (Gay Men's Health Crisis) and a myriad of other AIDS service organisations and treatment activist groups such as ACT-UP (Kayal 1993). Facilitated by a similar epidemiological distribution (the epidemic affecting largely gay men in the early years), the Anglo-American model of activism spread quickly to Canada and then to Europe. It was from this network of organisations that international aids agencies recruited personnel and from their collective experiences it drew lessons for designing and implementing AIDS control programmes across the world.

An emphasis on people with HIV "coming out" was also the product of a particular sociological conjuncture. Many of those who worked at the AIDS desks of international aid agencies were themselves North American and European AIDS activists who had become, by the early nineties, professionalised, and were in search of new challenges. By then, AIDS in the West was starting to become a commonplace issue — AIDS clinics were relatively well funded relative to the early years, and doctors, scientists, and government were taking the problem far more seriously than they had 10 years before. Key activist *cum* bureaucrats, if not themselves HIV positive had worked, lived and loved people with HIV. For them the epidemic was a reality they had themselves experienced directly, through the illnesses of friends, lovers, and even themselves. The stakes in "humanising" the numbers were personal ones.

People with HIV were the key to fighting the epidemic, they said, because they would help to overcome denial by "giving a face" to the epidemic: making the numbers "real" would help to make people change their behaviour. Who wants to wear a condom because of a statistical construct? An important subtext to this was that people with HIV and AIDS, were those who were closest to the "realities" of HIV and AIDS and best positioned to react, being , so to speak, on the "frontlines" of the epidemic,. This view became official dogma at the November 1994 Paris World AIDS Summit, where the Greater Involvement of People living with HIV and AIDS ("GIPA") initiative was ratified by the countries attending, essentially becoming the official policy of the "donor community." For those in the AIDS industry, GIPA represented an important milestone: the acknowledgement at the highest levels that people living with HIV and AIDS were not victims or objects of

policy, but had a necessary leadership role. It was a victory over discourses of exclusion, representing a watershed in the history of public health; a turning point whose precondition was the politicisation of experience that had occurred in the 1960s and 70s.

The local market for testimonials and the moral economy of disclosure

If the burkinabè authorities were desperate for a testimonial in 1996, it was because pressure had already been building already for a number of years. International agencies pointed to the presence of testimonials in other countries as evidence that a "culture of denial" around the epidemic was lifting, and that the fight against AIDS was progressing. Such evidence, it should be added, helped keep monetary aid for AIDS flowing. In so doing, many of those in authority were oblivious to the fact that these testimonials were emerging as a response to their policies, policies that encouraged these testimonials. These incentives went as far as outright remuneration for testimonials, in effect creating a market for them. For burkinabè and international agencies operating in Burkina, the situation in neighbouring Côte-d'Ivoire was the most visible reference point.

In early 1994 in the Ivoirian metropolis of Abidjan, the staff of development agencies looked on approvingly as three young people came forth to "come out" as HIV positive during a meeting attended by government officials and local groups organised to discuss the AIDS problem. "At last, to have been able to see these courageous young people affirming themselves" sighed one World Bank official, Madame Janvier, when I asked her to recount what happened at the meeting.

It was a moment of vindication for her and others in the "donor community", as the ensemble of development agencies are often referred to collectively. Their suspicions of government indifference to the AIDS crisis, nurtured by a history of denial by African governments in the 1980s, had hardened after years of trying to pressure the government to act with little in the way of concrete results. Programs funded by agencies were implemented by the government at a snail's pace, accompanied by endless seminars and haggling over details. In many respects this

was business as usual: seminars were needed, after all, for agencies to explain their programs and train those who would carry them out (whether government workers or NGOs) on how to implement them. Inevitably couched in the standardised language of the development industry, which measures success in terms of outputs, outcomes, impacts, and their indicators, such workshops would initiate participants into the intricacies of the financial accounting, paperwork, and vocabulary of particular programs. The functionaries who attended the workshops were only too happy to get away from the office for a day and, most importantly, to earn a daily fee, or *perdiem*, for attending the workshop. But for Madame Janvier, and others, things could not continue "as per usual" when it came to AIDS. The consequences of the epidemic were "dramatic" she said, recounting her travels to hospitals in various parts of the country. The figures were bad enough, but to see the suffering that she saw in these hospitals, and to know that barely anything was being done which could have an impact, was of great concern to her.

So it was perhaps not surprising that the three young people, Dominique, Jeanne, and Étienne, who went on to form Côte-d'Ivoire's first organisation of people living with HIV/AIDS, became the darlings of the development agencies. Funding became readily available, as well as invitations and plane tickets to meetings abroad. But Madame Janvier later came to have regrets. She felt that it was all "too much" for them: "they always look exhausted, they're always on airplanes. It's too much for their health." Madame Janvier was not alone in singling out the tendency of the new activists to travel frequently. It was a source of much jealousy on the part of those who joined the new organisation, and other aid workers occasionally accused colleagues of "showing off" their "pet" Africans with HIV at international conferences in a game of one-upmanship.

If such strategies at one-upmanship were conceivable, it was because the international community had indeed placed a premium on finding "real" Africans with HIV. This was particularly evident in West Africa, where people who were living with HIV and were willing to talk about it were slow to come forward. By then, eastern and southern African countries like Uganda, which had more mature epidemics, had organisations that could speak about "living positively" and "counselling," and iconic figures — artists, relatives of politicians — who were "openly HIV positive." Perhaps the development agencies that make up the

"donor community" were reacting to the frustrations of the Madame Janviers in their ranks, so that, somehow, during that period, "real" people with HIV came to represent that "something is being done." Officially, testimonies by people living with HIV were evidence that "supportive environments" were being created, and with it the right context for "effective prevention" which would result in "sustainable behaviour change". Members of the "donor community" regularly emphasised their belief that having openly HIV positive Africans talking about their situation would be taken far more seriously by their compatriots, unlike demonstrating condoms at a World AIDS Day fair booth. Yet when Jeanne was brought up to Burkina Faso to do her testimony on television, it wasn't taken that way. People laughed, and said that she didn't have HIV because she looked too healthy. "She's doing it for the money," they said.

For Abdoulaye, what was at stake through his fraternal adoption of Issa was very much a product of the GIPA initiative. By 1996, GIPA meant that Burkinabè authorities were desperate to obtain testimonials of people living with HIV. Testimonials had become, in essence, indicators of success for GIPA-compliant national AIDS programmes, and a key argument in favour of keeping aid money flowing to these programme. Indirectly, testimonials were worth money to the institutions that could furnish them, and as a result they were prepared to pay. But for Abdoulaye, and *Jeunes sans frontières*, testimonials could not be reduced to simple transactions. Issa's story — the letter in the paper — was exactly the kind of testimonial that was being sought after, something that Abdoulaye was not quite yet aware of when he read the letter and invited Issa to join the association in 1995. By late 1996, when the search for testimonials was in full-swing, Abdoulaye was already caught in a complex moral economy.

In monetary terms, *Jeunes sans frontières* functions like a business, selling development "projects": proposals to implement international development agencies' social policies. Most local non-governmental organisations (NGOs) are specialised in a particular sector, such as health, environment, women's issues, or agriculture. *Jeunes sans frontières* started out in family planning, gradually becoming involved in reproductive health issues. From there, involvement in AIDS education was a short step. But the organisation was more than a subcontractor; in effect, what it sold the international agencies was local knowledge to implement programs, most often in the form of convincing

evidence that such programs had been implemented. Organisations such as Abdoulaye's do not work in a vacuum, however: it is their embeddedness in local social relations, local networks of obligation and reciprocity, that gives them both their credibility and the local knowledge that is so valuable to international agencies. As a result, a large part of their work as "subcontractors" to large development agencies is to translate these social policies into locally meaningful knowledge and practice. In the case of *Jeunes sans frontières*, family planning money was effectively invested in job-creation for local youth (as peer-educators or outreach workers). In exchange for the labour which kept projects going, Abdoulaye paid his youthful charges a decent wage. Their enthusiasm impressed the organisation's funders, and their loyalty ensured that even in this desperately poor environment they could be entrusted with money and goods. Shrewdly, the organisation used these investments to develop a multivalent infrastructure — neighbourhood kiosks, a central office, scooters — onto which other money-generating projects could be piggy-backed.

Many of the key players within the organisation were members of Abdoulaye's extended family — not so much as a result of crude patronage, but because the presence of kinship ties meant that these individuals could be trusted. After all, in a setting of dire poverty and social precariousness, it is difficult to trust people whom one does not know, who are not tied to one by obligations. Interestingly, others who joined the organisation and established a reputation for reliability and "seriousness" became like family. Some even moved into the common courtyard house Abdoulaye shared with his many uncles, aunts, and their children. This was Abdoulaye's moral economy: a network of social relations where kinship relations and obligations furnished the idiom through which accountability and hierarchy could be expressed and transactions valued. *Jeunes sans frontières*' success was less a product of "good" management practice than Abdoulaye's skill at translating between this moral economy and that of the development agencies. Here lay his "charisma."

Bringing Issa into the family upset a delicate balance. With the entry of testimonials into the market, suddenly it was Issa's trust in Abdoulaye, his entry into a kinship relation as Abdoulaye's "young brother" (although he was actually older), that was commodified. By negotiating as Issa's advocate, Abdoulaye tried to re-establish the balance by attempting to ensure that Issa would get something

for his testimonial. Ultimately, Issa left, not because he felt betrayed, it seems. Abdoulaye told me that he began to doubt that Issa was HIV positive at all. He told me that, after a while, he found Issa "strange", and that the story he told in the letter didn't "make sense" to him anymore: "Africans wouldn't treat one of their own like that", he told me. Abdoulaye wonders now whether he was used, whether it was his trust that was betrayed.

Coming out against aids: from "empowerment" to competition and schism

For the development agencies, testimonials were the royal road to empowerment and self-help, a practice that would stimulate solidarity between people living with HIV and allow them to develop a sense of community that could sustain them through the difficulties of their illness. For those that testified, on the other hand, testimonials were not so much an idiom for expressing an illness experience as a strategy for accessing resources. At times, for development workers, this generated nagging concerns that tesifiers might be inauthentic, and that self-help groups were engaged in mimicry rather than genuine "empowerment." Tracing through the itineraries of early testifiers, no clear narrative — whether of empowerment or of inauthentic mimicry — emerges. Yet, clearly, as testimonials circulated they worked to transform social relations.

In Côte-d'Ivoire, the three young people who testified first at the national AIDS meeting back in late 1994, and then on television, did so before any obvious opportunity for material gain would have been obvious to them. Dominique often described a feeling of powerlessness, of having been left "in the dark" after receiving his HIV diagnosis at the country's only testing centre in downtown Abidjan. There was no one he felt he could talk to. This feeling was exacerbated at the meeting, where expert after expert rose to intone on the epidemic. "What about us?" was the thought on the minds of all three. None of them was prepared for what would happen after they stepped up to the microphone, said that they were HIV positive, and that they felt something should be done for people like them. They thought they would be ignored, but they weren't.

The Health Minister immediately promised them support, in the form of a place to meet at the headquarters of the national AIDS programme. Not long after, the invitations to speak came, as well as offers of "technical assistance" — to help set up and structure the group as an official AIDS organisation — and financial help. The constitution of the largest French AIDS organisation was faxed from Paris, and used as a template for the new organisation, to be called "*Coming out against AIDS*" after Dominique's experience of "coming out of the dark". The organisation's flowchart, with Dominique at its head, traced an impressive structure: a President, flanked by assistants who in turn presided over a plethora of *Comités*: *prise-en-charge*, *testing et conseil*, *éducation*, and so on.

Unlike Ouagadougou, Abidjan had an active HIV testing centre since 1994 and as a result there were far more people there who knew about their own HIV positivity, many of whom were not yet ill. A number of them joined the new organisation. With the ready availability of western sponsors in Abidjan, *Coming out against AIDS* was able to offer incentives for membership: subsidies for transportation costs to attend meetings. and, some hoped, the possibility of a trip abroad to attend a conference. Perhaps because organigrammes tend to be long on structure and short on purpose, what exactly *Coming out against AIDS* was supposed to do did not appear to be clear to many of the members. Discussions with their western sponsors, who had in mind such model groups as Uganda's *TASO*, encouraged *Coming out against AIDS* to develop outreach activities for the ill, and supportive counselling to others who had been diagnosed HIV positive. Such activities by the group's members were subsidised by the agencies from 1995.

More lucratively, group members receive stipends to testify about their HIV positivity in meetings organised by the agencies to promote AIDS prevention. Typically, a *Coming out against AIDS* member will stand up in front of a group of schoolchildren or factory workers or villagers and talk about being HIV positive. The testimonials are most often preceded by an information session where figures on the epidemic, modes of transmission, and the nature of the virus are presented and followed by demonstrations of condom use and question-and-answer sessions. These testimonials themselves often seem stereotyped: the testifier talks about how he too never took AIDS seriously, until — for one reason or another — he took the test and found out that he had HIV. Now, he is the wiser, takes

care of himself, and always uses condoms. In more intimate settings, some of the testifiers would often refer to their condition of knowing their HIV diagnosis as a form of enlightenment. Étienne once told me "the guys in the neighbourhood, they used to laugh at me; they probably thought they would be laughing over my dead body. But now I have travelled — I have seen Europe, South Africa. I have seen something, and they still know nothing"[8]. In their emphasis on the discovery of a "truth" that forever changes the discoverer and her behaviour, testimonials are rhetorically similar to stories about being converted or born-again.

But the core business of *Coming out against AIDS*, in the eyes of agency workers who shepherded its development at every step, was "self-help". For them, *Coming out against AIDS* would provide a forum — through the weekly meetings whose attendance they subsidised — where people with HIV could get together, share their problems, and be mutually supportive of each other. Most of these agency workers had met people with HIV in the course of their jobs, and had been party to the difficulties they faced. It was not–and still isn't — an easy litany to hear. In Côte-d'Ivoire, as in most developing countries, regular healthcare is unaffordable, except for a minority with health insurance, or the very wealthy. (As in the case of the schools, in this era of structural adjustment the public health care system charges user fees to "recover costs"; in Abidjan, these fees are now as expensive as those of the private health care system). Most of those who joined *Coming out against AIDS* had been ill — this was how they found out they had HIV in the first place — and had had to scrounge money from relatives to pay for an expensive prescription or an even more expensive stay in hospital, all the while expecting that this scenario would be repeated, and knowing that the resources would not hold out indefinitely. Some people with HIV had lost their jobs, their spouses, or their children to the disease. Knowing that one had HIV, as one informant told me, was "knowing you are condemned to a slow death and most probably being abandoned by your family and friends — not because they don't love you anymore, but because they can't afford to look after you, and won't be able to bear looking you in the eye because of that."

[8] Étienne's connections with AIDS organisations has enabled him to immigrate to a Northern European country, where he now resides.

Faced with the near impossibility for individual workers to resolve these social and medical problems, having a group like *Coming out against AIDS* to refer people came as a relief to the development workers. "At the very least", said a colleague of Madame Janvier's to me one day "they'll be able to ventilate." Dr Konaté, a French public health physician who trained at Berkeley in the late 1980s and took a particularly active interest in the group, was less sanguine. While in California, she had been impressed by patient activism and AIDS activism in particular, which at the time was just beginning in France. But clearly *Coming out against AIDS* was not quite the same kind of organisation. Through frequent and involved conversations with the women in the group, Madame Konaté had realised that the women "didn't have a voice" in the organisation, and that they felt little in the way of support at the meetings. She was struck by how *Coming out against AIDS*, and other organisations she worked with, "mimicked the State" with their "obsession" with Vice-Presidents, task forces, and commissions where nothing ever really happens. "I realised that in many respects it was just an empty shell."

Attending the meetings certainly would have, at first , given credence to Dr Konaté's impression of postcolonial mimicry and non-action. Meetings always began formally, opened by the President, or, in his absence, the Vice-President, followed by reports from members who had attended prevention workshops to give testimonials or gone to other meetings. Reports were often lengthy, and gave the impression of being used to justify the reporter's having done whatever he or she was reporting on; they were most often long descriptions of what had happened, or who had spoken about what at such and such a meeting. Members would only begin to talk at the end of the meetings, and then mainly concerning the difficulties of carrying out an activity which they had been commissioned to do. Often, these discussions would become quite acrimonious, with members accusing other groups, or even each other, of secreting away valuable resources. After all, it was certainly no secret that wealthy western agencies were giving money to the organisation, that the group's President and Vice President often had the opportunity to travel to Europe or South Africa or even America: So why, members asked themselves, was the group barely breaking even on bus fare to do home visits? And who was going to pay for their prescriptions when they got ill, as members were sure to become from visiting patients in the TB ward, or in the filth of the city's shantytowns?

The group, along with others, convinced the World Bank to fund a March for World AIDS Day in 1995. The March was from Adzopé, 50 km north, to the centre of Abidjan. Participants were paid to march and offer testimonials at HIV prevention events along the way[9]. The price of their participation had been energetically negotiated with the World Bank, and the rumours swirled that a French magazine had paid $ 500 for interviews with Africans with AIDS certainly served to increase the price. The fee for the marchers was finally fixed at roughly $ 100 US, but for only a limited number of participants from each group. But the first day of the March, more showed up than had been expected by the organisers. A small fist-fight broke out between a number of participants over the right to march and to receive the stipend offered by the World Bank.

Although news of the incident at the Adzopé-to-Abidjan AIDS March never officially got back to Madame Janvier, funding for a repeat event the next year never materialised. *Coming out against AIDS* continued to struggle the next year — funding was episodic, and matters were not helped by Dominique's illness. Despite this, Dominique went to the International AIDS Conference in Vancouver the next summer, in July 1996. He had gotten a plane ticket, at the last minute, from an embassy, and went on the long trip. But when he got to Vancouver he had neither money for the conference registration, nor for accomodation or food. Luckily, he had made enough contacts at previous conferences that he was looked after. But he was quite ill, and he died later that year shortly before World AIDS Day 1996. In death, old rivalries were forgotten. It was a typical funeral — several wakes in the city, followed by a "traditional" burial in his village. What was not so typical was the interest the event generated. Dominique's death was covered in a few local papers, and a large following of activists in different local AIDS organisations attended the wakes and travelled to the village for the burial. At the World AIDS Day parade, marchers could be seen sporting buttons that read "Dominique we miss you." Jeanne took over the presidency of the organisation.

In many ways the organisation never recovered; Jeanne never seemed to achieve the legitimacy of Dominique. She also travelled often, too often some thought,

[9] A telling inversion of AIDS marches in Northern countries, were marchers are sponsored and the proceeds go to organisations.

and a European AIDS organisation gave her a cell phone so that they could "get through to her at any moment." Rumours swirled around her. That she wasn't really ill; that she was ill and that witchcraft was keeping her healthy; that she was a witch; that she was a lesbian and a wealthy Swiss lover was keeping her; that her family had rejected her; that she had rejected her family. As the rumours about Jeanne proliferated through 1998, donors made clear their desire to shift their interest to "empowering women with AIDS" because, as one donor official put it, "women with AIDS is the new priority." Many of the women who had originally been in *Coming out against AIDS* left to form *Abidjan Women Against AIDS (AWA)*.

Thus, between 1996 and 1999, *Coming out against AIDS* splintered off into at least 5 groups, one of which retained the name and some of the members of the original organisation. Some of these splinter groups are referred to as "one man associations", ostensibly because they were formed by individuals seeking to access funding from development agencies. By 1999, the mantle of heated "donor interest" had passed from *Coming out against AIDS* to *AWA* (also a common female first name in Côte-d'Ivoire). Many of the women in *AWA* had found out they were HIV positive when they were pregnant by enrolling in French and American trials designed to test the efficacy of the drug AZT in preventing transmission of the virus from pregnant mothers to their infants.

Another group, which was originally set up by missionaries at an Evangelical AIDS care centre in a poor quarter of the city, has since acquired a reputation for being outspoken. Re-named *ACT-UP Abidjan*, it drew its name from its Parisian homonym (which is incidentally its main French sponsoring organisation), itself inspired by the radical New York group of the early eighties that pioneered Western-style AIDS activism. When *ACT-UP Abidjan* quietened down in 1999, many attributed their silence as to keeping their end of the bargain for having obtained triple combination antiretroviral therapy (which they could not have otherwise afforded) from a government programme.

Figure 8.2 • Positive Nation member.

If Dominique's testimonial was a watershed in Francophone West Africa, the subsequent evolution of *Coming out against AIDS* was consigned to relative obscurity. The story of the group's multiple schisms is unfortunately the norm — observers throughout Africa and elsewhere report the same phenomenon. Even though individuals may be willing talk about their experience of illness in public, development agencies have raised the financial stakes enough that competition over these material resources occurs between the ill. In this environment, the only rational strategy is to form splinter groups — at times "one man" or, more rarely, "one woman" associations — to more effectively compete for these resources. Schism has generated conflict.

Despite being a women's group, *AWA* has not been immune to the problems. The group had no headquarters, and held its meetings in the offices of a more established organisation, *Positive Nation*. As their name suggests,Positive Nation was one of the more outspoken groups, and through their media contacts had a platform — in the form of regular radio and newspaper columns — from which to air their views which were often highly critical of the government. They also had good connections to Abidjan's upper class, as well as a number of local benefactors who had supplied them with a house in the Abobo quarter of

Abidjan, and an office in a building in the central district of the Plateau. Like *Jeunes sans frontières*' office in Ouagadougou, the office doubled as both a reference library, cluttered with glossy brochures and lavishly illustrated pamphlets from Northern NGOs, thick WHO and World Bank reports, and a prevention and counseling centre where the groups' members would relay messages about safe sex, condoms, and loving people with HIV.

The house in Abobo was donated at the same time as some medical equipment and drugs, and the group decided to make it into a drop-in centre for people with HIV, not unlike *Jeunes sans frontières,* which independently opened a *Café solidarité* at roughly the same time. But the medical equipment stayed unused for two years, as the group proved unable to apply for and obtain funding to actually run a program at the drop-in centre. Gradually, as the centre accumulated other equipment — a computer, a photocopier, a television with a VCR — from other programs, *Positive Nation* members from the neighbourhood would gather to hang out, learning how to use Windows, or watching African music videos on channel 2. Because the space was largely unused, it seemed logical for the group to offer *AWA* space for meetings.

Eventually, one of the groups more entrepreneurial members, Yao, decided that it would make more sense for *Positive Nation* to go into business rather than waiting for hand-outs from bureaucratic aid agencies. The "*+Shop*" opened in late 1998, selling staple items: candies and gum for schoolchildren, biscuits, tinned coffee, milk and tomato paste, soap, sugar, rice. In its selection of goods, the *+Shop* differed little from other "corner stores" in Abidjan. However, there were slight differences. *Positive Nation*'s institutional credibility allowed it to raise funds from agencies that furnished a significant capital for investing the new business. For example, at Yao's suggestion, this capital was used to invest in a volumetric dispenser and a 400L barrel of palm oil which when resold in 100mL and 250mL plastic sachets, generating greater profits for the business. The photocopier donated by the UN was used to make free photocopies for other NGOs, but individual clients could pay for getting copies made.

The *+Shop* was a huge success, generating enough revenues to employ four people, one of whom was HIV positive,and who earned a double salary to cover her medication expenses. Yao, always looking for a new project, convinced the

group to reinvest the proceeds from the *+Shop* to setting up the *+Café*: a snack bar which could employ women from *AWA*. The project was agreed to, and by mid 1999 two thatched gazebos had gone up in front of the house. Under one were a half-dozen small tables, and the other covered a small kitchen. Yao had succeeded in persuading *Positive Nation* to buy two Chinese portable gas burners, more fuel-efficient than the standard, cheaper coal-fired hibachis. These heated the large wok-like pans (made from recycled palm oil barrels) used for deep-frying plantains, yams, and fish.

But *AWA's* involvement was less successful. Initially, none of the women wanted to work in the Café kitchen. Some said it was because "they feel like they only belong in offices", that they don't want to "get their hands dirty" frying fish. Others said it was because they felt they were not going to be paid enough. Yet when one of the women brought a cousin from the village to take on the job, the other women accused her of favouritism and hijacking the group's resources. After a few months, and only one major glitch — one employee had disappeared with the proceeds of the till — the Café had become popular with neighbourhood locals and was turning a healthy profit. But the women resented that the Café's profits were used to pay back *Positive Nation's* investments — in building the gazebos, buying the gas burners, plates, and cutlery. "Why should we work for them" they asked at increasingly recriminatory meetings. It was during this period that donor interest in *AWA* heated up. A large Berkeley non-profit organisation, "dedicated to empowering women with HIV," identified *AWA* as a "local partner." It funded *AWA* to organise home visits where *AWA* members would "peer counsel" other women with HIV. As is common in these programs, *AWA* had to account for the grant money it received from the Berkeley organisation by submitting reports of the home visits by the "peer educators" (the positive women of the group). Few visits were carried out, but who would fill out the reports was the focus of acrimonious debates at the group's meetings.

The dissensions that consumed *AWA* in 1999 stemmed from an argument over how resources were to be allocated within the group. *AWA* had come into existence in response to development agencies' desire to fund self-help groups of positive women. But the dynamic within *AWA* was not one of self-help and solidarity, but one of competition over resources; of "what's in it for me," as the Ivoirian representative of their Berkeley funder put it. This attitude was reinforced

by the implicit message of the agencies. "Because you are HIV positive you deserve our help", a message which *Positive Nation* took to heart in its sincere offer to help the fledgling group. Many of the women were deeply hurt by the acrimony and bitter exchanges, and what they felt was the injustice of the situation. All the women in the group struggled to get by in everyday life, but stark evidence of injustice stared them in the face every time they met. Some of the women had qualified for a program which allowed them to receive subsidised treatment with antiretroviral drugs, but the program did not have enough space for all the women. Over that year, the women on the medicines gained weight while those who didn't receive any got thinner and fell ill. Two of them died that year.

Two solidarities

Both *Jeunes sans frontières* and *Coming out against AIDS*, despite their different histories, illustrate a shifting and indirect confrontation between two models for creating social ties. The international development agencies' promotion of testimonials as a path to "empowerment" and "self-help" articulated a singularly western vision of solidarity. But these notions of "self-help" were only a partial and particular view of the networks of obligation, responsibility, and exchange that serve to both constitute persons and bind them together in Africa. Abdoulaye, Issa and the women of *AWA* were caught in local moral economies that at times put them in conflicting and even untenable positions. For them, dissolving these social relations was not an option — for who would look after them after the development agencies left or moved on to new issues? Who would look after their children? It would be simplistic to view these stories as reflecting the imposition of an alien order of social relations on reluctant but powerless individuals. Confronted with the threat of illness, these individuals were intent on reconfiguring social relations, and grasped eagerly at western models of solidarity even as they were only too aware of how little power they had over their material circumstances.

For anthropologists, kinship has furnished a central category through which the question of social ties or solidarity has been examined. Kinship, which significantly does not have to be the expression of a biological relationship, largely

surfaced as a concern in anthropology because it was thought to be central to the problem of politics, particularly in the colonial setting. Many anthropological studies were devoting to describing the formal, logical structures of kinship as a road to theorising the nature of society. But kinship was also understood in functional terms, as an explanation for how societies without formal political institutions (segmentary societies) were able to resolve conflicts among members and make decisions affecting the whole group. Kinship seemed to be a reliable map people used to decide who should be brought together to resolve conflicts, or to whom specific requests would need to be addressed. Practically speaking, for the colonial authorities, understanding kinship meant knowing who one's interlocutors should be and how to negotiate with them[10]. Based on these studies, anthropologists came to view kinship as a powerful idiom for understanding and enacting identity and personhood. In West Africa and elsewhere, whom one is as a person is expressed through the language of kinship — lineage, clan, descent.

Kinship is not static, and the background to the stories of *Jeunes sans frontières* in Ouagadougou and *Abidjan comes out against AIDS* begin to show how it has been stretched and reconfigured in the context of accelerating urbanisation, migration, and the financial interventions of development agencies. Here, "African solidarity" functions as a keyword for unpacking these reconfigurations. The concept of an "African solidarity" is a term which is as much a part of the everyday speech of Africans in Ouagadougou and Abidjan as it is of discussions of Africa by Europeans. It is most often raised in contrast to the European "non-solidarity" of old-age institutions and street people. "African solidarity" means that one always has a roof over one's head, that there will always be a common meal for sharing, even if there is not quite enough to go around. The basis for this "African solidarity" is, of course, still kinship: the extended family which in the urban setting often overflows lineage considerations to include those who are from the same village, or even the same "*éthnie*". This represents a dilution of the strict notion of kinship anthropologists used from the colonial era on.

Abdoulaye's return to Ouagadougou made him confront a more restrictive notion of kinship — his patrilineal kin, as is usual with his *éthnie*, the Mossi — than he

[10] The locus classicus of west African kinship studies is Radcliffe-Brown and Ford 1950. Leach 1961 made a cogent critique of formal models of kinship; the political context to the development of kinship studies is described in Kuper 1988 and Kuklick 1992.

had been used to negotiating in Abidjan. There, all Burkinabè were his "brothers", he said, as were those from his neighbourhood in Anoumabo — "there, we are at home," he confided to me. In this light, *Jeunes sans frontières* can be read as Abdoulaye's re-creation of the looser kinship of *his* village, the Abidjan *quartier* of Anoumabo.

Discourses such as that of GIPA, as well as the manner in which development officials represent and attempt to enact self-help amongst their African charges, are facets of a particular model of "self-help." For officials like Madame Janvier, mutual support is a result of talking, sharing, and discussing one's problems in a non-threatening environment. So imagined, self-help happens as people fluently articulate issues that affect them as individuals. In its imagination and its organisation, self-help is a form of community where individuals are brought together by their afflictions. In this case, being HIV-positive in Africa is not unlike belonging to Alcoholics Anonymous in America, or any number of other groups where people come together because of a shared physical condition. The testimonial, or public disclosure of one's HIV positivity, is crucial: being able to "come out" in a small group is a small step to the larger act of "coming out" publicly.

Looked at in this manner, self-help as a western phenomena contrasts with its African equivalent, organised and expressed through relations of kinship. Unlike self-help, kinship relations do not require the sharing of experiences and finding common grounds for action — they are enacted through the social order. The dilemma of Issa's testimonial was only the first incident where Abdoulaye was confronted with difficulties of translation between these two forms of solidarity. Another was his attempt to organise a self-help group of people with HIV.

Abdoulaye tried for many years to organise, as he called it, a "*groupe de parole*" ("talking group") of people with HIV who could come together and discuss their situation. *Jeunes sans frontières* always expressed its mission in terms of "African solidarity" for people with HIV, and at first glance it always seemed a logical next step for Abdoulaye to be concerned with setting up a "talking group". But the group didn't get off the ground for the first few years because no one wanted to meet in such a group, even though they knew that other members were in the

same situation. "What are we going to talk about?", or "people will find out," were the most common reasons for not speaking out.

Conclusion

Writing about the colonial administration of the Tiv peoples in Northern Nigeria in 1974, the British historian Jonathan Dorward used the term "working misunderstanding" to characterise the complex articulation of strategies that ensured the maintenance of a peaceful coexistence of colonial domination and native resistance. Drawing on more recent literature, one could speak of both colonial governmentality — the ways in which "natives" constituted themselves as subjects of colonial government — and postcolonial ambivalence: the always-shifting attributions of subjectivity and desire that characterised both coloniser and colonised. This account of how the trans-national AIDS control strategies of international agencies played out in local social relations bears striking similarity to these historical discussions.

That no clear narrative of domination — nor of resistance — emerges from this account is a reflection of two, inter-related phenomena. First, agency is above all a matter of pragmatism. In the face of HIV/AIDS, material survival is always the first priority. Most of those in this story — the members of the talking group that didn't speak, the women of AWA — do not have much control over their daily lives and if their agency is not visible in this account it is largely because they have little room to maneouvre While it might be tempting to see this as a "cultural" phenomenon, requiring the task of locating manifestations of agency in the realm of meaning-making, this would draw attention away from the structural conditions that relegate these individuals to a state of powerlessness. Faced with illness and death, medicines are the priority; not meaning.

On the other hand, meaning is a useful category for understanding the behaviour of those who do have the power in this story such as Madame Janvier and other well-meaning development workers. Whether in agency offices or in the "front lines" of refugee camps, these workers are confronted with a terrible reality — that of the statistics about the epidemic that give a centralised overview of its devastating scope, and the sheer volume of suffering one encounters in hospitals and NGOs — and the evidence of their powerlessness to intervene. The power of

agency workers to imagine solutions and enact them, even as structural constraints undermine their realisation, is visible in the efforts to bring about the "greater involvement of people living with HIV and AIDS."

As we have seen, it would be a mistake to view agency as a purely discursive construct: the GIPA initiative certainly has the ontological status of discourse, but its effects are both material and discursive. Nowhere is this more visible than in the trajectories of Abdoulaye, Étienne, Jeanne, and the other intermediaries in these stories.

The middling social spaces they inhabit on the margins of state retrenchment and humanitarian crisis are sites of translation, negotiation, and exchange; they are also zones that magnify the agency of those who occupy them. This will be the subject of the next chapter. The arrival of antiretroviral drugs injected a material correlate to discursive practices of "empowerment", inscribing inequality ever more dramatically in the bodies of those whom the development agencies sought to help, as we shall see in chapter 10.

Chapter 9
Workshops and techniques

Introduction

This chapter will focus on how international agencies stress the production of narratives about being HIV positive, and explore the impact these narratives have on the lives of those who have been cued to elicit or produce them. As discussed in the previous chapter, stories about being HIV positive, and practices of disclosure, figure prominently in the lives of community groups grappling with the AIDS epidemic. This is the result of policies enacted by development agencies, who were anxious to "break the silence" and "put a face to the epidemic." These policies unwittingly created a market where stories about being HIV positive could be bartered for access to resources. These narratives came in various forms, ranging from explicitly sought-after testimonials for formal public events and awareness-raising sessions, to stories told to others in search for help with a prescription. However these are not merely stories: the manner in which they circulate, who they are spoken to and how, can be a matter of survival, of getting someone to pay for medications[1].

Over the long term, these stories change the people who tell them. These narratives alter the tellers' social environment by configuring a new social network, through a self-help group, for instance. That is, illness narratives are

[1] As a strategy for accessing treatment, these stories can also lead to biological change. This will be discussed in chapter 10.

vehicles for reconfiguring social relations. In other words, these stories are neither representations nor mystifications: they are pragmatic (Lock and Kaufert:1998). These illness narratives, produced as a rsult of both biological states (being HIV-positive) and by institutional policies, are thus operators of social change.

The stress on "coming out" with one's story about being HIV positive is most clearly visible at workshops. Workshops are not marginal or unusual events. The shift away from large, infrastructural development projects — such as building dams — to social programs that aim to "involve local communities" changed the development model from a "top-down" or vertical approach to a more horizontal approach. As a result, large agencies favour sub-contracting programs to "local partners," usually as a result of pressure from their funders. This shift to a more decentralised model echoes changes in industrial production that resulted in an emphasis on "flexible," post-Fordist production, outsourcing, and increased reliance on contractual labour to achieve more "nimble" corporate structures.

With this shift to a more collaborative model, workshops have become a central component of international agencies' activities "in the field." They are a fundamental element of development agencies' programmes, and a significant component of development agencies' budgets, usually under the rubric of "technical assistance." Workshops, where the implementation of programmes with local "partners" (such as *Youth without Borders* or *Positive Nation*), teach the skills necessary to implement the programs, and to monitor their progress. For the local partners, workshops are occasions for ensuring renewed funding and for scouting out other opportunities for support.

The advent of a "flexible" model of NGO-driven development means that most development agencies do not invest in infrastructure or social programmes, and are often required to rely on paid consultants because precarious funding makes it impossible to hire local paid staff. Thus, from a strictly economic point of view, workshops are an ideal vehicle for development interventions as they are far less expensive than programs that directly address the material needs of target populations. Limited to the cost of airfares, consulting fees, *per diems* (daily expense allowances) and hotels, workshops have little in the way of imponderables and once they are finished do not generate any ongoing costs. Furthermore, workshops contribute to development agencies' credibility in two

ways. First, they count as "program outputs". By being defined as an indicator of program implementation (for example,"train 100 village outreach workers"), when they are held they count as evidence that the programme was carried out ("100 village outreach workers were trained at a workshop"). Second, they are sites where evidence of programmatic success are collected by development agencies for presentation in the reports they produce to justify funding. The photographs, boxed case-studies, and testimonials that figure in development agency reports are usually gathered at workshops, for the simple reason that head office staff and paid consultants do not have the time to travel out to isolated villages to collect this evidence.

The participants of these workshops also favour them: in an the era of structural adjustment, many civil servants are paid derisory salaries, if they are paid at all. *Perdiems* for attending workshops can make up the significant part of a civil servant's or an NGO employee's salary, especially when the *perdiems* paid are UN or international agency rates (enough to cover an "international-class" hotel). Local participants stay with friends or relatives and use the difference to cover the new incidental costs of living: school fees for children, medicines, and so on.

One could argue, albeit cynically, that workshops represent a strategy for institutional self-perpetuation. In this view, workshops are the grease that keeps the machinery turning, designed to never solve the problem they are meant to address while showing steady progress. Institutional discourses can either legitimate the failure of intervention by setting up tangential goals, like "empowerment", which, even if achieved, are unlikely to lead to any meaningful improvement in peoples' lives, because the constraints economic conditions impose on their agency are so great (legitimation strategy #1). "Empowering" poor women to negotiate condom use skills with their partners is unlikely to be very effective when poor women are economically dependent on men. When they are not this may be an important intervention. Alternating these discourses can set up goals, like "care and support", for which the industry cannot provide the means to achieve those goals — medicines, administrative support, competent personnel and health care infrastructure. In this case, not achieving the goal is attributed to an inability to achieve "sustainable" or "cost-effective" programs (legitimation strategy #2). This leads easily to an institutional form of blaming the victims, who

are never organised enough, competent enough, or self-financing enough, to "run with the ball."

However, it would be a mistake to view development interventions in general, and workshops in particular, as futile exercises in either institutional perpetuation or as discursive constructs that perpetuate their own epistemology. Although they most often fall far short of stated goals, as we saw in the previous chapter, development interventions are appropriated by local individuals and organisations to further their own goals, while simultaneously keeping to the spirit — if not the letter — of the program for which they were funded.

This chapter argues that workshops are sites where trans-national institutional discourses — such as "Greater involvement of people with AIDS" or the GIPA initiative discussed in the previous chapter — are translated into practical, local interventions. As will be shown, the work of translation relies on particular social technologies that are portable across different cultural environments, and are able to produce effects that can be taken up in local networks of practice and signification. Workshops also allow a privileged glimpse into how international consultants and local workers interact, shedding light onto how differences in opinion, goals or strategies are reconciled or elided. This is illustrated below, in an ethnographic account of a workshop that focussed on teaching counselling skills to African AIDS NGO workers.

Warm-up exercises

I want you to close your eyes, and to think of someone that you love very much — think of him, think of all the good times you've had together. Think of him, and tell yourself now "I've got AIDS. I've got AIDS. I've got AIDS!". Think of him, and think of how you've got AIDS. Now, open your eyes. Take a piece of paper, and draw a heart. In that heart, write what is in your heart now, when you think of this person you love very much, and then give the paper to your neighbour on the right.

It's early in the morning, 1996, the second day of a meeting of African AIDS NGOs, and Theresa has been asked to do a "warm-up" exercise for the group. Her delivery is dramatic, almost frightening. Theresa is a project officer from the head

office of a large funding organisation in Washington; she told me later she made up the exercise on the spot "to get people into the feel of things". My neighbour, on my left, gave me a crumpled piece of paper which I never opened. I was so uncomfortable with the exercise that I didn't fill out my heart. Theresa never did tell us what to do with the tiny hearts we all received; after about a year I mailed it back to the shy woman who had given me hers.

I'm going to hand out six of these yellow post it notes. Now. Think about your work doing community support for people with HIV. Take three of the post-its, and write a word which expresses what your fears are about this work. And take the other three, and write your motivations. Now, one by one, everyone should go up, share your words with the group and and stick them either on the appropriate flipchart: this one is for "fears" and this one is for "motivations".

One by one, the workshop attendants place their words on the flipcharts, reading them out as they do so.

> Fears
> Enough. Tired. Suffering. Suffering. Fragility. Exhaustion. Powerlessness. Suffering. Death. Inability to save from death. Patient confidentiality. Getting overwhelmed. Spiritual and physical suffering. Rejection by society. Lack of psychosocial support. My limitations. Support. Patient resources. Dying. Interruption. Telling the truth. Contaminated. Lack of resources. Suffering. Difficulty to approach. Fear. Economy. Suffering. Pain. Limits. Rejection by others. Fatality. Money. Availability. Disease without a cure. Propagation. Public's ignorance. Pain. Not being up to it. Pain. Discouragement.
>
> Motivations
> Compassion. Will to help. Vocation. Personal. Worrisome reality. Support. Pursuing an option. To serve. Helping others. Overcome. Compassion. Useful. Knowledge. Solidarity. Compassion. Fears. Anguish. Help. Love. Help save. Helping others. Overcoming sickness. I could be sick. Comfort. Help. Comfort. Support. Help. Despair. Abandoned. Suffering. Suffering. Love. Be useful. Suffering. Abandon. Spiritual need. Compassion. To serve. Ignorance. Fear. Solidarity. Concerned. Difficult situations. Contribution. Regrets. Love. Hope. Discover myself. Friends who are affected. To learn.

My neighbour is Aïssatou, a young mother of two. Aïssatou joined a group for women with HIV six months ago, after several bouts of illness which led her doctor to test her for HIV. He was the one who recommended that she join the women's group. She feels that her husband has "withdrawn" from her since she told him the news. He is often away on business. The only person she can talk to, she says, is her doctor. He has been available to her in a way that is unusual for most local physicians, who must see enormous numbers of patients and tend, perhaps unconsciously, to prioritise those with "treatable" illnesses such as malaria or gastroenteritis. She recalls that he spent 15 minutes with her when he told her the diagnosis, even hugging her at the end of the appointment, and has twice made an effort to see her ahead of the queue when she has travelled to see him with her concerns. Aïssatou and I met through a mutual friend, Catherine, who had introduced us so as I could offer Aïssatou advice on her illness.

Catherine was also at the workshop. I had first met Catherine a few years before, when she was still a social worker at a medical research centre which was evaluating AZT in the prevention of mother to child transmission of the virus. The centre had a long and illustrious history, having been the headquarters for colonial infectious disease eradication programmes throughout French West Africa. As a result, it was the logical home to the few AIDS clinical trials being run in the area. Catherine's professional exposure to AIDS was as a counsellor to the pregnant women who were enrolled in the trials. After a bout of illness prevented her from continuing her job, she set up the organisation as a "gesture of thanks" to the women with HIV, her clients at the centre. Their visits and support during her own illness, she told me, had been enormously important to her and she credited them with being able to overcome her illness. The new organisation aimed to offer "psychosocial support services" to women with HIV — Catherine told me she had been disappointed that the research institute had been unable to continue looking after the women who had found out they were HIV positive by enrolling in the clinical trials program, but were subsequently found to be ineligible because of medical reasons.

Aïssatou's doctor had referred her to Catherine's organisation. By the time of the workshop, Aïssatou and I had known each other for long enough to gossip about other workshop participants during breaks. Catherine's boyfriend, Salifou was also at the workshop, but, it turned out, they were no longer together. Aïssatou

told me that Salifou's family had disapproved of the liaison, and they had decided to break up even though they were still very much in love with each other because they knew they would never be able to marry.

It was initially through our gossiping relationship that Aïssatou came to confide about herself in me. Her worries about her health had led her to borrow money from her family so that she could start a small business on the side: she invested in a small gas stove which she used to heat oil to fry plantains. "It's not glamorous" she says; after all, she was lucky enough to have had a good education and graduate from high school with the Baccalaureat, "but it's a little something". That little something is almost three dollars a day, which she saves to pay for medicines. Her two girls are 5 and 7, healthy, and precocious.

At the workshop, Aïssatou's yellow post-its ("Lack of psychosocial support", "Spiritual and physical suffering", "I could be sick") appeared to express her experience of her condition in a way that she would never have put into spoken words. She remained silent throughout the workshop, except during the warm-up exercises which, as one facilitator noted, weren't as "solemn" as the post-it exercise. These were games where a ball is thrown, or a form of musical chairs called "fruit salad" is played, or songs sung. Nothing personal was involved.

Asking questions

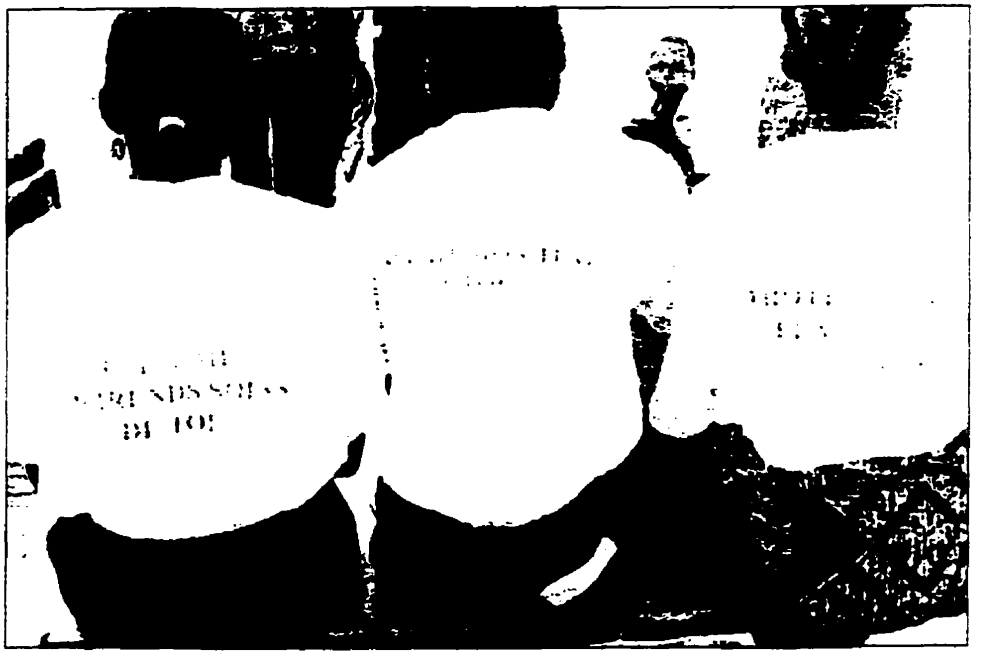

Figure 9.1 • Asking questions: AIDS self help group.

The rest of the workshop was consecrated to training Aïssatou, Catherine, Salifou, and the other participants chosen from other community groups funded by the Washington organisation, in techniques for looking after the HIV positive people who come to them for help. This was referred to as "care and support," a term that emerged after several years of linguistic haggling within international NGOs. Theresa's Washington boss, Juan, explained to me that "treatment" was "too medical," pointing out that the "medicalisation of the epidemic" had been one of the most significant barriers to activism in the early years in the West. By medicalising AIDS Juan implied the allowing of doctors, bureaucrats, and other "experts" to manage the epidemic, something that AIDS activists with Juan's background are particularly mistrustful of. Juan's move to Washington marked a shift from volunteer work in a French AIDS organisation to a paid job in an international AIDS organisation. But his mistrust of AIDS experts stayed with him through the transition. This is not surprising given the profound impact of the French tainted blood scandal on the perception of the medical establishment and the State in France: the scandal led to the imprisonment of senior physicians of the National Blood Bank, as well as the indictment of the Minister of Health and the Prime Minister at the time. (One of Juan's field officers, a British man, referred

to the money France was spending on AIDS in Africa as "guilt money" subsequent to the blood scandal.) But Juan could have just easily been from America as from France. In the early years of the epidemic there, government and medical inaction were blamed for deaths of people with HIV either because inadequate resources and approaches were used for prevention or not enough was done to care for those who were ill.

Being able to communicate with HIV positive people was a principal goal of the workshop. Participants concentrated on learning "active listening" techniques: how to ask open ended questions such as "How does that make you feel?" or reformulating a statement: "when I fall ill no one will look after me"; on suggesting a response: "you're afraid of being abandoned?" And at the same time mirroring their interlocutor's posture. All this to build up confidence,in order to "reassure your interlocutor and prove to him that you are really there".

Ask the person you are helping how she is feeling.
Of course, asking just "are you OK" is not enough. The person you are asking can answer with just "yes" or "no".
You can ask her "how are you feeling?". She can then answer that she is feeling well or unwell, and then continue to express herself.
But it is better to ask "what are you feeling?" "what are your feelings?" "how are you emotionally?" etc.

And it's even better if you can link each emotion or feeling she expresses to something precise: "how did that make you feel?" "what are your feelings about that decision?", "that's a difficult situation to be in — how do you feel about that?" etc.

It is preferable that the person you are helping responds by truly describing her emotions:
--she should be encouraged to speak in her name, in the first person. For example: "they are telling me that I am depressed"
What counts is not what others say, but what this person truly feels:
--avoid thoughts which interfere with the expression of feelings, for example:
"I think I am exhausted"
"I feel like I am getting discouraged"
--it is preferable that the person be able to say

"I feel very depressed"
"I feel full of hope today"

The workshop used a number of techniques which are widely used in training in the development industry (as well as in private industry). In addition to the warm-up exercises there were "trust-building" exercises, such as having one person stand in the middle of a circle with their eyes closed. She would let herself go limp, and allow herself to be tossed around and caught by other members of the group. Pairs or groups of participants practiced their "Communication skills" (the active listening techniques) using drills:
"ask nothing but open ended questions for three minutes, then switch. When the time is up, have each member debrief on what the experience felt like."
Participants did role plays in front of the group in order to practice their interviewing skills. After each role play, the actors would be debriefed:"how did you feel during the exercise?" And members of the audience were asked to observe the body language and the techniques used. Care was taken to avoid overt criticism of actors' techniques; conveying an attitude of "non-judgementality" was important.

"Facilitating" the workshop

As a "facilitator," Theresa played a key role. The workshop had been "designed" to fulfill its objectives according to a script not unlike a musical score. Indeed, the script was impressively detailed — each session had thorough notes of what was to happen, and was calculated down to the last minute. Post-its, flipcharts, balls, and the other material supports to the workshop were inventoried and prepared beforehand. Theresa likened her role to that of an orchestra conductor — she only had to follow the score, "reading" the participants the way a conductor would "read" her musicians. In her description of the importance of "distributing speech" evenly amongst the participants, as "they should all have a voice," Theresa indicated that the *materiality* of the workshop extended beyond the post-its and flipcharts to embrace the *process* itself, which could be sculpted and handled as if it were thing-like.

Daily "debriefings" were attended by all the facilitators, every day after the workshop was over. At these meetings, Theresa never dealt with the problem of unduly timid or disruptive participants in terms of personality or personality judgements, but as "factors" which needed to be dealt with mechanically. Theresa knew of Aïssatou's seropositivity; in the meetings she spoke of the difficulty of having to "steer" discussions she thought might be difficult for Aïssatou — notably about death and dying — in such a way as to be sensitive to Aïssatou's perceived fragility, without at the same time making it obvious to the others in the group that this was being done.

Theresa's orchestral metaphor was borne out by the fact that the facilitators did not evaluate the success of the day's sessions in terms of compliance to the elaborate detail of the schedule. Rather, discussion centred around issues of emotional tone and "flow:"

"the participants are starting to unwind; I think the warm-up worked very nicely,"
"it's a good sign, I hardly had to call on anyone, the discussion circulated nicely amongst the participants,"
"Aïssatou seems less timid today, I think she's starting to process the material better."

The work of the facilitators was aided by their script: the elaborate "pedagogical plan" had been worked out on an Excel spreadsheet, with rows allocated to each chunk of the workshop divided according to theme, and columns allocated to objectives, methods, activities, materials and so on. The spreadsheet was adjusted every night, based on the conclusions of the meeting: sessions were abridged or modified according to facilitators' perceptions of what "had worked" or "needed more work." Both the debriefing meetings and the spreadsheets highlighted the material nature of the workshop. The workshop contained finite quantities of "discussion" to be parcelled out as distributed speech; every participant had a voice quotient to be met. Silence was greeted as failure. The participant's psyche contained an emotional content to be "processed" through the workshop, the results of which were legible in terms of how the participant "engaged" with the material: was she still "too involved" or did she achieve a distance? As a result, the spreadsheet could be juggled to achieve the right results. And the workshop appeared inherently *workable*.

The most difficult content of the workshop concerned what Theresa called "maintaining boundaries," that is, "knowing when to let go." Participants mentioned that they found it odd that they were being trained to encourage their charges to speak of their affliction while simultaneously "not taking it to heart." As this concern became apparent, Theresa invented a new concept –"setting limits"-- to aid the participants, which was written into the script at one of the debriefings. Theresa chewed on a pencil as she presented her idea: she was worried that such talk of "limits" might be "too negative." The title of the exercise was eventually amended to "boundaries and resources." Exercises were developed to get participants to reflect on what their "limits" were, and how they would know when they had been reached.

But of course, not everything could be scripted. Role-plays could go awry, or an exercise could fail in its intended purpose. Participants often brought up difficult interpersonal situations they had faced: counselling a bereaved relative, or a worried mother. I asked Theresa how it was that she always seemed to know how to advise the participants on what to do in these specific situations. "My experience on the phone line" she answered "means that I've actually encountered every one of these situations, or something very much like it. All I have to do is recall similar situations, and think of what I did which worked best. There's never a right answer — you just learn with experience, what the best things to say are, what kinds of questions you need to understand where your caller is. It's just experience: that's the importance of organising these workshops: learning from sharing experiences."

"hello, aids help?"

The Brussels AIDS helpline Theresa volunteered at is not unlike other such helplines in big cities. Callers ring up on a toll-free line, and are connected to a volunteer who answers their questions and offers supportive listening. The office is set up like any other call centre, with banks of phones and computers where calls are registered and information gathered. A panel display high up on one wall indicates the number of calls waiting, and the number of callers who hang up.

Like the other volunteers who worked at the line, Theresa had gone through a training workshop not unlike the one she was now running in Africa. She had learned the same techniques, using the same vocabulary and the same drills. During the debriefings with the workshop facilitators, Theresa often referred back to and shared her experiences at the helpline. She recalled that most of the calls were fairly repetitive — people would ring up anxious because a condom had burst, or requesting apparently straightforward information about HIV and the way it was transmitted. In those cases, skillful use of the listening techniques would quickly reveal the motivation of the call: the caller had been unfaithful and was trying to evaluate how risky their sexual encounter had been. At the time, in Belgium, information about HIV had already been widely disseminated, and so Theresa attributed these urgent dial-up needs for information to "guilt attacks." These calls peaked at regular times — weekend nights and Monday mornings, once guilty spouses had reached the office and were out of earshot: at those times, the incoming call indicator would glow bright red, indicating a backlog of calls and signalling the volunteers to be as expeditious as possible.

Other calls were "more challenging." A few came from regulars that the volunteers soon enough became familiar with: Theresa characterised them as "lonelyhearts," people who had no one to talk to and would call up the AIDS help line "just to talk — you know, Brussels can be a pretty lonely place." At first they made up stories, "perhaps because they felt that it they didn't have an HIV reason to talk to us we would hang up on them". Theresa suspected that they also called up other help lines, such as the suicide line or the psychiatry line, with different stories tailored to fit these lines' particular speciality. These were the most challenging cases, because "they can't be managed with a simple intervention — you know, counselling, referral, closure." Some of these callers could be "quite manipulative," "laying guilt trips" or even threatening suicide should the volunteer taking the call appear too brisk or dismissive. While the "lonelyhearts" represented a challenge because they required quite a bit of skill to handle successfully, others were more "emotionally difficult." These were the occasional calls from people with AIDS in moments of personal crisis. Occasionally, people with AIDS would call for medication information: this was "easy" as it was a simple matter of "referral" to the doctor on call. But the "crisis calls" had to be handled by the volunteers, and the skills required to handle these well were what Theresa had come to Africa to impart.

Theresa told me the training was "fundamental" to her ability to deal with the calls: it provided her with a repertoire of techniques to use in dealing with callers. But her phone line experience had exposed her to an enormous volume of calls representing a relatively restrained number of situations, much in the way that staff at an airline call centre is ultimately dealing with only a few different situations: making a reservation, purchasing a ticket, inquiring on the schedule for a particular route.

Theresa is a sensitive and caring individual, and this clearly played a significant part in her ability to offer support to the phone line's callers. But Theresa claimed her actual effectiveness in achieving "results" — discerning the true motivation of the call, orienting the caller to another resource, delivering the appropriate advice — derived from her repertoire of techniques, and, as she put it, her "skills" in using them to achieve those results. Not coincidentally, the workshop was often referred to as a "skills-building" workshop. A large part of her skill derived from her having tried different approaches on a trial-and-error basis and having determined, from that experience, what techniques were effective. If the training provided her with a grammar of techniques, on-the-job experience allowed her to generate narratives from her callers: narratives of infidelity, of worries, of loneliness.

Telephone help lines are an example of a confessional technology, where sophisticated telecom systems and techniques of active listening serve to collect and centralise narratives of distress, purifying them of any social content in the same manner that hospitals sort patients by organ system pathology. As a confessional technology, the help line produces capacities, such as Theresa's ability to know what to say. It also shapes the subjectivity of both its callers, who seek reassurance or advice in moments of vulnerability, and its operators, whose use of the skills they acquire there inflects their interactions with others, and even their social relations, in novel ways. The central issue for Theresa was how to transmit her skills to her African interlocutors. Interestingly, the usefulness of her help-line experience suggests that these confessional technologies may be more portable than technological infrastructures.

Despite the materiality of the workshop and its contents — post-its, flipcharts, exercises, techniques, and spreadsheets — it is an eminently portable affair. Like many other workshops, this one was moved from Brussels to a number of West African capitals in the form of facilitators sitting in the coach section of a Belgian aircraft with the binders, post-its and a flipchart stand neatly stored in the cargo hold. The techniques employed in the workshop had themselves travelled from California, where they were first used in the mid eighties in workshops for training "buddies" of people with HIV. In the early years of the epidemic, AIDS organisations trained volunteers to work with people with AIDS: keeping them company, assisting them to negotiate doctor's appointments and hospital tests, even helping in everyday chores. These volunteers were called "buddies." The buddy system exists to this day in North America and Europe, though the demand for it decreased first in the early nineties as social services adapted to the problems faced by people with HIV and even more after 1996 when the introduction of new effective combination therapies dramatically reduced illness and mortality of people with HIV.

Emphasis shifted from training buddies in San Francisco and Brussels in 1996 on the tide of a rhetoric about"sharing experiences." Washington's support for "sharing experiences" reflected the consensus in the development industry in general, and amongst organisations attempting to address the AIDS epidemic in particular, that successful interventions needed to be reproduced rapidly to have an impact on the growing epidemic. The term of "international best practice" emerged as the key articulation of this consensus by 1997[2]. But to qualify as an "international best," practices had to be applicable in different settings, that is, they had to be portable. Certainly, the exercises and drills used in the workshop were portable, as were the techniques used to convey them. Asking questions that cannot be answered by a "yes" or a "no" is a technique that can be used anywhere. However, as became increasingly clear to Theresa during the workshop, getting people to elaborate after being asked open-ended questions was difficult. Laconic answers proliferated. It was difficult to get participants to elaborate their answers, even to the open-ended questions. This frustrated Theresa — in this case, because it meant there was little "material to work with" in her training sessions. Theresa

[2] As we shall see, "international best practice" and the urgency with which interventions are reproduced meant that many practices were disseminated before it could become clear what their longer term impacts were on communities.

never asked herself whether, once outside the workshop, the yield of the listening techniques might be just as meagre.

The monotony of the answers suggests that there were "technical difficulties" with the techniques being used. Despite their portability — the ease with which they could be moved from one setting to another — the techniques, when used, encountered a static of local interferences. The nature of these technical difficulties was twofold. First, the gaps, evasions, and circumlocutions resulted from participants' shyness in talking about personal difficulties. For them, talking would not solve the problem that lay elsewhere, in the difficulties of their material circumstances and the social relations around them.

Second, the techniques made certain assumptions about the relationship between asker and teller that did not hold in this local setting. For Theresa, asking questions with "good technique" was a sign of caring, a way of demonstrating "empathy." However showing "empathy" is one form of social relations. As will be discussed below, the notion of empathy attributes a moral value — caring — to a particular social interaction (that of asking questions). In the workshop, it was assumed that applying the technique of asking questions would construct a social relationship of caring. This assumes that questions are asked in a social vacuum. As will be shown below, this was not the case. The workshop participants always found themselves embedded in already-existing social relations when they returned to the "field." These social relations, and the material circumstances in which they occurred, meant that applying the techniques did not necessarily translate into empathetic social relations. As a consequence, participants used other techniques to construct a caring relationship. This underscores the role of workshop participants as mediators, or translators, of development discourses.

Translating empathy

The workshop stressed "attitudes which favour communication in the helping relationship"; one of which was empathy, that the workshop manual defined as follows:

Empathy is neither antipathy nor is it the sympathy we may feel for someone who is dear to us
It is trying to feel and think what the person we are listening to feels and thinks; it is trying to see the world from his point of view, AS IF we were in his place. But we must never forget this AS IF: because we are never in the other's position
Empathy is the attempt to totally understand the other, without referring to one's own values

I had an argument with Theresa about the meaning of the word "empathy." It seemed to me that the definition offered was not correct, that empathy was precisely not about the *AS IF*. Theresa's response was not semantic, but practical. She had joined the Brussels AIDS organisation after her brother was diagnosed with HIV. She had encountered the term at a workshop in Brussels when she was training to become a counsellor on the Brussels AIDS help-line. She had learned the term in translation. The term, she told me, came from Roger's psychology. The organisers of the Brussels workshop had themselves trained in America, at one of the original AIDS organisations in San Francisco. The point, she forcefully reminded me, was that something was needed to "maintain boundaries" so that counsellors would neither get overwhelmed with the emotional distress they would face, day and night, on the phoneline nor respond defensively with damagingly judgemental statements like "why did you do that?" Mobilising her own experience, Theresa translated empathy — a term she herself learned in translation — into a set of practices for making sure the workshop participants would take home the *AS IF*.

Aïssatou was called upon during the workshop to propose a situation for a role-play to practice empathy skills. She observed the role play she had proposed impassively. It concerned a young HIV postive woman who was upset by visiting in-laws' disrespectful treatment of her. In the role play, the young woman was counselled by another workshop participant, Salifou. Salifou had been instructed to practice the new communication techniques. Afterwards, the group was asked to "debrief" by commenting on Salifou's use of the techniques and his body language, considered markers of his ability to express empathy. Aïssatou didn't offer any observations on how her role play was acted out. Theresa struggled to get the group to analyse Salifou's performance "without being judgemental", correcting the "he didn't do this" and "he should have done that"'s of the group to

more "objective" descriptions, such as "he switched from open to closed questions half way through the interview," or, "more reformulation at the beginning of the interview might have aided the process." When it was Catherine's turn to comment on the role-play, she focussed in great detail on the openness of Salifou's posturing and the responsiveness of his body language, unwittingly betraying her empathy for him.

Aïssatou lives in a small one storey concrete house in one of the city's sprawling suburbs. It was when I paid a social call to her there, a few days later, that she introduced me to a gaggle of brothers-in-law who where staying there in her husband's absence — he was away travelling on business. By then her five-year-old daughter, Aïsha, was getting used to me and came to sit beside me as we exchanged greetings. After a while I realised that the scenario she had proposed for the role-play a few days earlier perfectly described the situation she was quietly complaining about to me. Sisters in law had come and criticised the state of the house, and she felt as though her husband had deposited his brothers there to "keep an eye" on her. As the conversation continued, I wondered whether she had offered the role play because she had felt pressured to do so and hadn't been able to imagine any other scenario than that which preoccupied her at the moment, or whether it had been her way of seeking advice without having to actually step forward and reveal her difficult family situation.

A year after the workshop, she had saved enough money from selling fried plantains to open a phone booth. A significant initial investment was required to build the booth, purchase the phone, the counter for calculating the cost of the call, and the deposit with the phone company — the phone booth was far more profitable than the fried plantains. "And it's cleaner too!" Aïssatou pointed out to me when she showed me the installations, clearly more cheerful and expressive. The new income enhanced her autonomy but most importantly earned her new respect from her in-laws. And the phone allowed Aïssatou to call a handful of friends abroad whom she had met through the workshops and other meetings she had gone to. Aïssatou hopes that her intensified contacts with these Westerners means that they will be able to find a treatment for her. But she confided to me that she was still having problems with her husband. For Aïssatou, then, talking was not the answer to her difficult marriage and material circumstances.

Cicely, a robust church leader and health care activist in a northern town, organised her own workshop after she left Theresa's. She used the workshop to train volunteers in her neighbourhood association, the *Friends of Life Association.* The workshop was translated into the national language, Mooré. The Mooré word they used for empathy, Cicely told me, translates back as "making other's problems your own business." The Friends also found the techniques useful, and had the added advantage that Cicely's unflagging determination had netted them a substantial stock of medications from Europe.

Aïssatou's and Cicely's stories reflect differing strategies for translating "empathy." For Aïssatou, what was at stake was gaining economic independence from her husband, and building up a network that could support her should she fall ill. Although she understood and could use the techniques demonstrated in the workshop, she never did make use of them afterwards. Nonetheless, the workshop allowed her to develop connections that eventually translated into access to medicines. Similarly, while Cicely's translation of empathy did not reflect the sense that Theresa had given it, it was well adapted to the practical work of her volunteers. They did, in fact, make other peoples' problems their business, by going around and doing home visits. But after all, Cicely pointed out to me, "in Africa, everybody sticks their nose into your business — what's wrong if one takes advantage of it to do good?" The problem Cicely and her volunteers faced was that good deeds were measured in terms of relief from symptoms, and not from stories told. She too was able to use contacts that came out of the workshop to obtain medicines. But it was never enough, she told me. Cicely was able to translate both the vocabulary of the workshop, but more importantly, she was able to translate the social relations she constructed at the workshop into tangible benefit for her association's clients.

Applying techniques in the village

For some participants, learning the techniques and applying them involved changing themselves and, through this, the social relations around them. This was the case of Justin and his group, the "Parish Companions." At the workshop, Justin had had difficulty with the role plays, finding it difficult to act in front of the group. Justin was a catechist from a remote rural area, who had been

identified by the funding organisation several months earlier. Washington had sent consultants who had been charged with finding community groups that would be able to do "care and support" work. Justin was the leader of a small group of catechists that performed home visits to people who were ill, presumably with AIDS. The "parish companions", like others in their village, assumed that those who were persistently ill or bedridden, most often those who had come back from the city, were suffering from "the evil of the century" (the local euphemism for AIDS).

They had been inspired to do this by the head of their parish, a young Italian priest who had become notorious in the region, and in the Catholic Church as far as France, as somewhat of an AIDS crusader. Father Giuseppe, as everyone called him, had developed educational tools — in the form of pamphlets and a game — which stressed that the only way to be safe from AIDS was to either be celibate, faithful, or use condoms. It was rumoured that his subsequent repatriation to Italy was because he had not been squeamish about promoting condom use. He told me he left Africa because his mother was ill.

His departure left the "parish companions" groups leaderless. When the consultants from Washington came, Justin was eager for an opportunity to "re-energise" his group's efforts. The Diocese seemed uninterested by the "parish companions", who nonetheless continued to visit their charges without being completely sure what they should be doing. The offer from the Washington consultants was quickly taken up, and Pascal, a "companion of the ill" from another parish who was also a clerk at the Diocese, travelled with Justin to the workshop.

The presence of doctors, nurses, and other "people of the Health profession" intimidated both Justin and Pascal at the workshop. Although both were literate, they had never pursued their studies beyond middle school and hence were not "intellectuals" like the others. On the first day of the workshop, Justin confided to me that he did not know how someone like him, who was not "of the profession" and did not have any scientific knowledge, would be able to understand anything having to do with such a medical topic. In the first few days, Justin and Pascal were clearly uncomfortable, their performance in the various role plays was wooden. But the workshop's emphasis on drills and practical skills appeared to

work. By the fifth and last day of the workshop, both Justin and Pascal would confidently ask open-ended questions.

Their enthusiasm for the workshop actually increased with time. Washington was eager to nurture their investment in the Parish Companions, and provided more consultants to ensure that Justin and Pascal maintained their skills and would pass them on to their fellow Parish Companions. As they attended successive workshops, a clear transformation in Justin and Pascal could be observed. They had left the first workshop with a mechanical ability to ask open-ended questions; by the third workshop, they summarised mock interviews with ease and had shedded their previously stiff habitus to fluidly mirrror the postures of their mock interviewees.

The village where Justin lives lies in an arid region in the interior of Burkina Faso; the paved road ends 100 km before reaching Doumla. On the edge of the road which passes Doumla is a small wooden stand with a dozen recycled glass bottles of various sizes, which glow amber from beneath the parasol which shields them from the bright sun. As a petrol trader, Justin travels weekly to the nearest big town, which is also home to the Diocese, to purchase a barrel with which he replenishes these bottles. These trips enable him to maintain a direct line with the Diocese, a link which also enhances his position as a catechist in the village. Doumla, because of its position on the road, is an important village in the area. It even has a small primary care centre, staffed by a nurse from the Ministry of Public Health. The dispensary is rudimentary, equipped with a few instruments for bandages and a tiny pharmacy which is most often empty.

Lying in a drought-prone zone, the health of Doumla's inhabitants is precarious. The town has never been struck by famine, but many of the village's children are clearly chronically malnourished. As a result, it is not surprising that epidemics of infectious diseases such as measles regularly sweep the village, killing many of the younger children. The village was also twice devastated by meningitis epidemics, which killed scores of villagers. Nuns working in a Catholic dispensary linked to the Diocese down the road had been to Doumla at the time, and told me of bodies having to be "carted away in trucks". These deaths were never recorded by the public health authorities. The nuns attributed this to local officials' embarrassment at not having been able to prevent the epidemics, as vaccines and

medications to combat the disease had never made it to the village even though they had been reportedly been donated.

But these are quick deaths, different from AIDS. "With AIDS", says Justin, "people lie ill in the family courtyard until the family can no longer afford to care for them". When the medicines which the family has scraped together enough money to purchase no longer work, after lying ill for some time, it becomes clear that the "evil of the century" is at work. Justin told me, that he has seen cases of families who "abandon" their ill — not by casting them out, but by leaving them without food or even clothing – a clear case of rationing scarce resources, and devoting them to those who are likely to live. This is when the Companions step in, to visit and bathe the sufferer and "restore his dignity." Justin was worried about the Companions becoming identified as an AIDS group — if that happened, their visits would carry the burden of stigma to their charges.

In addition, in a village where everyone knows everyone, as well as the degree of relatedness between everyone, it might appear odd for Companions, who are not kin, to visit a sick person. This initial hurdle was sometimes a problem, Justin admitted to me, although it was not such a big problem most of the time because "everyone is used to Church people going around and visiting ill people". The Catholic Church has been active in the region since the 1920s, when the first parish was established. The Diocese still has the dusty notebooks of life at the mission in its early years: details of visits to neighbouring villages totalling conversions by name and religion of origin, minutes of Parish meetings, report cards evaluating native catechists in training with comments such as "a good boy — hardworking, honest", "serious", "not bright but earnest."

As their home visits continued, Justin's initial worries about stigmatising those he visited abated somewhat. When I recalled his concerns, he noted that "in a way it doesn't really make a difference", as everyone "knows already." I had asked the question when the Companions had already had a year of open-ended-question-enhanced activity. The public health nurse in the village, Jean, who had not attended the workshop but had learned of the new techniques from Justin, could barely contain his excitement when we discussed the results of the workshop. "It has transformed the dispensary" he told me. Now that he had begun to ask open-ended-questions, "the patients are more at ease". Formerly laconic, now, "they are

talking". I asked what they were talking about, what this meant. "They talk about their problems: money, family problems". What difference has this made? "They have to confide, in a way they never confided to me before...it forces them to have confidence." When I asked what this meant for their health, Jean pointed out that health is a "vast thing," that even though there are still no medicines in the dispensary and the patients do not have the money to pay for medicines, they are "relieved" that they have been able to share their problems: and that "counts for something" too. This trust might translate into patients coming for care earlier when they are sick, which means that their illnesses might be more treatable, assuming they can afford the medicines.

Justin noted that the techniques had given the Companions "access" to the ill that they previously did not have. "The families resisted" home visits: now they are "brought to gain confidence". He told me of previously distant fathers who have become attached to him, and of a woman who confided intimate problems to him "which in our culture a woman would normally never confide to a man." One hundred kilometers back down the dirt road, at the Diocese, Pascal reported the same phenomenon. He even began using the techniques outside of his work with the Companions, in his regular job as the Parish Secretary. "Parishioners come to see me about all sorts of problems, like establishing birth and death certificates, including deaths that have happened in Côte-d'Ivoire." These deaths in Côte-d'Ivoire trigger Pascal's suspicions: "that is where the sickness comes from," and this furnishes one of many opportunities to ask more. Invited to confide in the parish secretary, the parishioners appear to do so willingly. "It helps them" he said, and allows him to feel that he is doing a better job.

Justin and Pascal were able to learn and apply the techniques because they were already embedded in social relations where questions are usually asked. Local people allowed for behaviour that could be considered meddlesome from catechists or Diocesan clerks because these were people in positions of authority. When Justin and Pascal asked questions, people answered readily because they felt they had to in order to get favourable treatment or access to the resources the institution these individuals were associated with had access to. When Jean, the nurse, asked questions, this surprised locals — public health workers are usually haughty and resent their postings to isolated areas. The questions were welcome, because they suggested that more resources might be forthcoming.

The workshop participants from the city were less enthusiastic about the results of the workshop. Medicines are more accessible in the city than in the countryside, and patients more readily assume that someone who is coming to enquire about their health is a medical professional, rather than a missionary for instance. The urban workers were thus confronted with their inability to supply what patients — and they themselves — wanted most: medicines to alleviate suffering. This led to some of the workers handing out symbolic quantities of medicine: three tablets of metronidazole for diarrhoea, for instance (a normal course would require six tablets a day for 10 days). Or they would prescribe tests. Although the results would not lead to any improved chance of treatment, at least it gave the impression that "something was being done". To "stand by" and "just ask questions" would be "just doing theatre," the workers said.

As someone perceived to be allied with the outsiders who had brought in the workshop, the participants I interviewed and followed were careful to praise the workshop. "It was empowering" they noted, to be able to use and teach the various techniques and to have "shared experiences". But over and over, the problem of material need came up. "These people have treatable illnesses, yet there is no money for medicines" they noted. Washington had made it abundantly clear that, while sympathetic to the need for medicines, it would not be possible to pay for them on any systematic basis. "Programs have to be self-sufficient: funding could run out next year, and then what would you do?" Washington pleaded, "this is about development, not charity".

Conclusion

"Listening techniques" and empowerment workshops demonstrate the material nature of the discourses of self-help explored in chapter 8. In the examples above, in the absence of material resources — money, drugs, or food — it is the techniques that are material. Despite this absence, however, some workshop participants are able to "translate" these techniques into material advantage for themselves or for those they wish to help. How this happens will be explored in the following chapter.

An important effect of these techniques is that they generate social change, by changing individuals and, through them, the social relations they are embedded in. These techniques are a form of confessional technology, in that they give individuals strategies for talking about themselves or making others talk about themselves. This is not without effects. In his *History of Sexuality*, Michel Foucault argues that the modern self is no more than a sedimented residue of confessional practices that have accumulated over the centuries. The reflexive interior-oriented self we may take for granted was fashioned by the obligation to regularly confess one's sins. Foucault would later cite these confessional practices as one of many technologies of the self, in the process loosening the mechanistic determinism of his earlier discussions of confession to embrace the notion that individuals fashion themselves by adopting technologies which correspond to dominant — or contestatory — social ethics. This still leaves open the question of why confessional practices, for example, are so historically robust.

Theresa's translation of empathy, from its Californian formulation to Ouagadougou via Brussels, suggests a reason. Open-ended-questions, and the accompanying techniques for "favouring communication in the helping relationship" as a package of confessional technologies, are strikingly portable. They are easy to carry, from America to Europe, to Africa, and they work everywhere. In fact, one European AIDS organisation referred to its fledgling attempts to develop an "international program" in Africa as the "transfer of community technologies." In addition to being portable, these techniques are reproducible. Drills, role plays, and trust-building exercises play an important role in stabilising the effects these technologies produce across different individuals and different cultural environments.

Chapter 10

Biopolitics: antiretrovirals, capital, and transnational activism

Introduction

The issue of access to treatment for people with HIV in Africa is a lens through which the interpenetration of social and biological change may be viewed. The AIDS epidemic spawned a broad transnational coalition of activist organisations that, as we have seen in chapters 8 and 9, has worked with community groups in Africa to translate the biological condition of being HIV-postive into novel forms of social relations, effecting social changes at the local level. This chapter will show how these novel forms of social relations, in the way that they determine access to antiretroviral drugs, result in biological and social change.

These biological changes result in improvements in health that register both in individuals' embodied experience but also in others' perceptions of those individuals. This has a social impact, weakening the association between AIDS, and death and dying. It also reshapes subjectivity, as individuals' experience of the benefits of treatment encourages them to be more public about their condition, in some cases becoming treatment activists. Access to treatment is conditioned by a variety of macro-level factors: "Big Pharma" (as the

pharmaceuticals industry is called in health activist circles), contemporary trends in capitalist concentration and rationalisation, intellectual property law, and actions by states and their proxies to defend national, commercial interests. However within this landscape of constraint, therapeutic modernism affects biological changes by texturing this global inequality with micro-level inequalities of varying intensities and durations.

The life-cycle of pharmaceuticals

Pharmaceuticals are ultimately material objects that circulate as commodity-forms. That is, they are *produced* — and marketed — by capitalist firms, and are *distributed* through a variety of mechanisms that may or may not be profit-driven, including their prescription, and are *consumed* within therapeutic economies (*cf* chapter 7, Van der Geest 1997). For anthropologists, the "social life of things" (Kopytoff 1986) has emerged as a concept that extends the study of material culture to the way in which objects are used in everyday life and are productive of social relations. Consumption studies have focussed on how consumption practices can be read as manifestations of agency. In this view, consumption represents practices that shape and consolidate identity, and it has even been argued that these practices may express resistance to dominant political forms (Miller 1997). Focus on consumption has been at the expense of attention to practices of production and, even more significantly, research into those parts of the world where consumption is forcefully constrained by material need is severely lacking. The notion that things have a social life holds the promise of a synthetic method within which relations of production, exchange, and consumption may all be accounted for (Appadurai 1986). While a social biography of HIV drugs — particularly antiretrovirals — is beyond the scope of this chapter, it offers a roadmap for navigating the complexity of the issue of access to treatment. This roadmap indicates the links between "consumption" of medicines — and the biological changes they effect — and the broader political economy of drugs production, marketing, and distribution.

This study will track backwards, starting with the biology of treatment, and will then draw on ethnographic data to illustrate how social relations determine

access to treatment that, in turn re-configures biology and social relations. Moving beyond the social networks agents mobilise to access therapy, this consideration will explore a host of intermediary factors that condition the availability of antiretroviral drugs. These mediating factors can be viewed as discursive formations: particular concatenations of discourses — ideas, representations, and rhetorical styles — and practices that, although organised like neither institutions nor states, nonetheless exert tangible biosocial effects. This has been shown in the discussion of GIPA (chapter 8) and in the use of confessional technologies (chapter 9). In connection with pharmaceuticals, the impact of transnational discourse coalitions, and the marketing needs of the pharmaceuticals industry, will be considered.

The therapeutic revolution of HAART

In 1995, clinicians in North America and Europe began to see the benefits of what then was an experimental treatment paradigm that relied on combining multiple anti-HIV drugs (called antiretrovirals, or ARVs) in the treatment of HIV infection. The paradigm emerged with the development of a new class of drugs, protease inhibitors (PIs), which target a crucial enzyme that the virus requires to reproduce itself. Previous drugs had targeted reverse transcriptase, the virus's "signature" enzyme that allows it to transcribe its RNA back into DNA (see chapter 1) and are accordingly referred to as reverse-transcriptase inhibitors. Protease inhibitors are remarkably powerful antiretrovirals; however, resistance to treatment with these drugs was found to emerge very quickly. As a result, the idea of combining drugs with the PIs was advanced as a strategy for delaying resistance. The strategy, and the new treatment paradigm it defined — combating resistance through strategic drug combinations — revolutionised HIV treatment. By late 1995, HIV clinicians had all seen dying patients return to health with the new drug combinations. New viral load tests showed that the drug cocktails suppressed viral replication to the point that HIV was no longer detectable in the blood, and with treatment biological tests showed that patients' immune systems were being restored. The adoption of so-called highly active antiretroviral therapy — *HAART* for short — had an enormous impact, reducing deaths from AIDS by over half in industrialised countries during the first few years of their use. After 14 years of bad news, it was almost too good

to be true. Flushed with optimism, at the 1996 World AIDS Conference in Vancouver, under the slogan "One world one hope," researchers debated the possibility of curing patients with the drug cocktails. Although eradicating HIV from patient's bodies is no longer considered feasible, the advent of HAART marked the advent of a therapeutic revolution akin to the discovery of insulin for the treatment of diabetes. An illness that was previously fatal, in most cases, within a few years of diagnosis, is now treatable and, in the current state of knowledge, there is no evidence that patients should not expect to live indefinitely with treatment.

Treatment with antiretrovirals changes the biological condition of those with HIV. Under ideal circumstances — perfect adherence to treatment with a three or four-drug regimen — this viral load is reduced and this consequently allows immune systems to recover and treated individuals to regain their health indefinitely. The current challenges of HAART is to sustain patients' adherence to therapy, and develop strategies to reduce the toxicities of these regimens over the long term. Contingencies in accessing treatment raise specific issues concerning individual and public health.

Partial adherence to treatment — as in the case of interrupted drug supplies — incompletely suppresses viral replication and leads to the development of a drug-resistant virus in that individual. Drug-resistant viruses may be transmitted and generate epidemics. This has already been documented by molecular epidemiology studies in Switzerland, and in North American cities 5 to 10% of newly infected individuals — who had not yet received any treatment — were infected with a drug resistant virus (V Simon et al: 2001, Yerly et al:2001).

Despite their high cost, ARVs made their way to developing countries almost instantaneously. For the wealthy or the well-connected in poor countries who have always sought out health care in Europe or America, access to HAART was not difficult. And as for any other commodity, a small black market in the drugs sprang up immediately. Their small size and high cost makes them particularly attractive for illicit trade. Almost as quickly, however, transnational networks of solidarity sprang up as individuals in Europe and America sent drugs to sick relatives or friends. These networks also linked individuals who

had met through their involvement in AIDS activist causes, leading to the intertwining of social activism with biological activism, as we shall see below. These pragmatic solidarities are now becoming more formal, as "drug recycling" programs and organisations start to spring up in Canada, France, and the USA.

From diagnosis to therapeutic activism

In late 1997, Abdoulaye travelled to Europe for the first time — he had been invited by a French NGO to come and attend a workshop. Travelling to France, former colonial metropole for Francophone West Africa and the primary reference for all that is western and "modern," was enormously exciting — an opportunity that few Burkinabè would ever have. By then Abdoulaye was spending most of his time putting together HIV projects for *Jeunes sans frontières*, and once in Paris trips to the Eiffel tower, the *Louvre* and the *Champs-Élysées* were complemented by visits to the French AIDS organisations whose material Abdoulaye had been reading and whose names were by now important references for him. Abdoulaye took the "exchange and sharing of experiences" purpose of the trip seriously, and as he had been writing about HIV testing centres and counselling groups he visited all of these. He also had an HIV test, which turned out to be positive. Parisian friends found a doctor who was able to supply him with triple therapy for himself.

After he returned from Europe, inspired by the self-help groups he had seen there, Abdoulaye convened — but did not participate in — a discussion group of people who had come to him because they were HIV positive and had heard that *Jeunes sans frontières* was involved in the "fight against AIDS." However none spoke about being HIV positive. Discussion centred around the details of everyday life and the difficulties of getting by. By 1999, Abdoulaye was faced with a new problem. Some of the people he had invited to the group, he realised, were better off than others — some of them were even able to pay for some form of medical treatment. This would surely "inhibit" any of the kind of fluid discussion that was important to mutual support. "It will only create jealousies and frustrations," he concluded.

During the time he was trying to set up the "talking group," one of Abdoulaye's "aunts" in the family compound fell ill. (She was the daughter of his paternal uncle, and therefore his cousin and in fact younger than him; however as his uncle is the senior brother of Abdoulaye's father he referred to her as his "aunt"). She had been ill for some time, and unbeknownst to her she had tested positive for HIV at the local hospital. As is customary, the diagnosis was confided to her father, the head of her household, and he had summoned his knowledgeable Abidjan-educated nephew to discuss the matter. Abdoulaye arranged for medical care, and made sure that she was properly looked after and that her medications were paid for. Her diagnosis was never discussed. She died six months later, not having been told she had AIDS.

The difficulty Abdoulaye had in starting a self help group indicates that "telling" is indeed difficult in settings such as these where sheer poverty could magnify even minor inequalities, the potential for jealousy, and the undermining of solidarity — a consequence that was seen in the discussion in Chapter 8 of the rivalries and schisms that characterised verbose self-help groups such as *AWA* and *Coming out against AIDS*. In settings of numbing poverty the Western dream of self-help, characterised by perfect sharing and caring (chapters 8 and 9), is more illusion than practical strategy. However, uncontained disclosure also has the potential to upset social hierarchies, such as those in Abdoulaye's family, that have been negotiated over long periods of time. Glossed over by Abdoulaye and others as part of their "culture" ("Mossi culture is highly hierarchised" was a standard introduction to many of his project proposals for the development agencies), hierarchy also serves a practical purpose. It holds families together, instituting a clear and stable system for allocating household resources including decisions about what share of resources should go to health care for household members. This is a robust form of solidarity, perhaps conquerable to that instituted over decades and even centuries by large stable institutions such as the Church and State. It certainly appears more robust than the model of self-help advocated by western agencies.

Between 1994 and 1999, it seemed as though the disconnection between "coming out", or talking about one's experience of being HIV-positive, and "solidarity" or self-help, would remain refractory to the best efforts of westerners to bring them together. For the development workers, such as Madame Janvier, that I spoke to,

it seemed obvious that self-disclosure was cathartic and a first step to the organisation of therapeutic social relations. Although Abdoulaye told me he believed this too, this was belied by the differential manner in which disclosure occurred around him.

Abdoulaye told me that, after his initial depression upon discovering he was HIV positive in Paris, he did not speak to anyone about it. After all, whom could he trust in Ouagadougou? As the leader of *Jeunes sans frontières*, he told me he was afraid that "it would discourage everyone in the group, if they find out that even I am positive too". Abdoulaye's disclosure of his positivity to me, and his friends in Paris, echoed his earlier justification for confiding about Issa to me, that "Europeans" could all be trusted as outsiders. Through 1998 I received more information by dribs and drabs: about his girlfriend Fatou's long illness and her subsequent diagnosis, then that she had borne him a daughter they had named after his mother. I found this out in a laconic e-mail received 3 months after her birth; Abdoulaye signed off with: "I hope she will live."

Early in 1999 *Jeunes sans frontières* embarked on a new project. The "Friendship Centre" was housed in a small house with a courtyard in an outlying neighbourhood of Ouagadougou. As *Jeunes sans frontières* developed a higher profile, people with HIV were being referred there from local physicians and even the National AIDS Control Program. Abdoulaye, inspired by what he had seen on his trip to France, conceived of the Friendship Centre as a combination drop-in Centre and dispensary. An erratic flow of medicines from concerned friends in Paris made for a small stock for the dispensary — "nothing much," but certainly better than what was available at the nearby State-run dispensary where years of World Bank mandated cost-recovery had long ago emptied the pharmacy.

The Friendship Centre was successful in attracting people with HIV in its first year — even though there were not enough medicines, there was always at least a warm welcome afforded by Madame Février, the volunteer receptionist. Madame Février had come to the group after her husband's death, which she believed had been caused by AIDS. Widowed, and with three small children to support, she had come to the group to ask for support — Abdoulaye couldn't offer her a job, but as she was an older woman he thought she would have the right social stature to be the Centre's receptionist. He suggested she volunteer, and he would do his

best to make sure that enough would come her way that she could keep paying her children's school fees and put food on the table.

As the volume of patients grew, an informal camaraderie struck up in the house's living room, which doubled as a waiting room. With its two wooden benches around a small table, a shelf-full of AIDS literature, and a large colour television and VCR, the room was airier than the organisation's headquarters. The TV and VCR had been obtained through a World Bank program[1]. The patients often sat watching the television, unaware of its complex genealogy, exchanging long formulaic greetings as others arrived or left. All of them had at some point learned they were HIV positive, and all of them knew that the others were HIV positive too, and some were visibly ill. Yet never, in those first months of operation, did they discuss this situation amongst themselves.

Youth without Border's World Bank television set was a welcome source of diversion, but ultimately *poulet télévisé* (the local term for the chickens grilled on a spit, referring to their presentation behind a window) would have been more welcome. Talking about being HIV positive was of little relevance when the pressing concerns were about getting food and medicines.

Things began to change, however, in early 2000. By then, Abdoulaye had been on his antiretroviral treatment for three years, managing with donations from his

[1] The project was, World Bank officials said, to be a "new model" for development cooperation: "local NGOs partnering with the State to develop the country." The project was launched in a curious manner, at a workshop to which NGO representatives and civil servants had been convened. Presumably the sign of the Bank's new participatory approach, the workshop participants were asked to work in small groups to put together the procedures through which the program would be implemented. But the workshop bogged down when participants complained that their daily allowances (*per diems*) were inadequate and that they were being asked to do the Bank's job for free and, besides, no one had asked for the program and this was just another example of the Bank's imperialism. Replies to the effect that this was the going rate for perdiems, that this was a chance to have a say in how programs were implemented and that they were all represented on the World Bank's Board because one of the directors was an African were hooted down. The workshop's degeneration foreshadowed an administrative imbroglio which led to lengthy delays. The project's intended beneficiairies, local NGOs, pointed the finger at government bureaucrats who they said were reluctant to share; government officials blamed the Bank's unwieldy bureaucracy and local NGOs inability to meet the Bank's stringent criteria for eligibility or their unreasonable demands for vehicles and buildings which were not covered by the loans. Amid the acrimony and recriminations, *Jeunes sans frontières*' bid for support bore fruit, almost two years after the initial application by the organisation. The request for the TV and VCR ("for prevention and awareness raising") had been approved in Washington within the first year, but the international tendering process for the equipment had added another year to the process.

Parisian doctor. Together with him, Abdoulaye had devised a treatment plan to deal with erratic supplies; he would just switch medicines according to what he had on hand, making sure that he had at least 3 different and complementary drugs. He had bought a small fridge to store those medicines that had to be refrigerated. As a result, by late 1999 his T4 cells had shot up, from 14 to over 400; his viral load had been undetectable for almost three years[2].

He put on weight, regaining the stocky build of his early twenties. Fatou also thrived with a stock of medicines from Montréal, but his daughter Salimata was often ill with fevers. While this is not unusual for a child in West Africa, Abdoulaye was distraught every time she took ill. For the first year of life, HIV tests are unreliable as infants have their mother's antibodies and, Fatou being positive, Sali would have been positive too. By the time she was two, Sali still had not had a test even though it could have been reliably ascertained whether or not she had contracted HIV from her mother at that point. By that time, Abdoulaye had resigned himself to preferring uncertainty — punctuated by attacks of anxiety every time Sali had a fever — to the possibility of definitely finding out his daughter had HIV.

Meanwhile, Aboulaye's visible recovery was not without an impact on his surroundings. Rumours circulated that he had supernatural healing powers, and this brought a new influx of the ill to the Friendship Centre. Those who knew about his consumption of medicines did not suspect HIV, he told me, because he had always been "easy to take medicines," a modernist quirk that his Ouagadougou friends assumed had been acquired in Abidjan. His stock of antiretrovirals seemed ostentatiously modern, laid out in their brightly coloured boxes by the foam mattress he slept on in the adobe room in the family courtyard where he lived.

The doctor in Paris was also impressed, having "never imagined" that such a striking clinical response could have been obtained with rotating medicines and a long-distance therapeutic relationship. As a result, in early 1999 he began sending Abdoulaye away with armfuls of medicines that he collected for other patients in

[2] A normal T4 cell count is over 600; with less than 50 cells, patients are at high risk of serious opportunistic infections and death within the year.

Ouagadougou. By 2000, Abdoulaye was telling some people he was HIV positive, but "only my friends who are taking the test or have taken it," he told me, "because only they can understand." That year, he moved out of the family compound. His daughter's frequent illnesses had led to his aunt's mother being accused of witchcraft by the other women in the family compound. As I helped him pack up his antiretrovirals in their pristine packages, Abdoulaye told me he was "tired" of these "African stories" and wanted a holiday.

Faced with the influx of newcomers at the Friendship Centre, Abdoulaye tried again to start a "talking group." However, the patients maintained a slightly awkward silence. Discussion invariably turned to the problems of material subsistence. In the words of a European psychologist who tried to work with the group, "these people are completely overwhelmed by their material needs and difficulties — how can you expect to do any psychological work until these more basic issues get resolved?" But with the arrival of medicines, things began to change. With circumspection, Abdoulaye and an inner circle of Friendship Centre staff began to carefully — "little by little" — distribute the medicines.

He explained to me that they used the talking group to identify candidates for the medicines — those who came regularly were more likely to observe the rigorous treatment schedules, and those who "contributed" most to the group were favoured. These "dynamic" members should have access to treatment, they reasoned, because they would be able to help others more than those who remained passive. The "talking group" began to fulfil a function unintended by those who championed it as a model of self-help: it served as a kind of laboratory for determining how to identify those who should have access to treatment. Thus, the self-help group functioned as a triage system, a method for determining who would benefit most from medicines — just as in wartime, when military physicians must decide who of the wounded can be saved and who cannot.

Abdoulaye's, and *Jeunes sans frontières'* story is not unique. On the contrary, it is the norm. Community groups involved with AIDS inevitably have many HIV positive people who know their diagnosis amongst their members — either because they join these groups in the hope of getting access to treatment or they take the test themselves (as Abdoulaye did) in order to "practice what they preach." Encouraging testing is one of the pillars of development agencies'

prevention strategies, the argument being that testing is a powerful tool for raising awareness and changing behaviour. In countries with a high prevalence of HIV, the odds are good that some of those tested will turn out to be HIV positive.

These organisations, like *Jeunes sans frontières*, inevitably find themselves drawn into the issue of treatment for their own members as well as those that come to them for help. Ultimately, access to treatment is contingent on social relations and the ability to capitalise on social networks. *Jeunes sans frontières* made treatment decisions based on a social calculus: who would translate improved health into the greatest good for others? This explicit form of local triage is, however, the exception. The lucky few who obtain antiretrovirals do so through contacts with Northerners. For these individuals, the key to survival is to be able to "tell a good story," as Issa did (chapter 8). Issa's story eventually landed him in France, where an AIDS activist took him in and obtained a residency permit for him. The French authorities, like other European countries, quietly renew foreigners' residency permits when they are HIV positive, subsequent to domestic political pressure denouncing early deportations of HIV positive Africans. Jeanne and Étienne also live in Europe now, having arrived there the same way that Issa did. For those who stayed behind, Jeanne, Étienne, and Issa are the truly lucky ones, whose stories got them to Europe.

The UNAIDS Initiative: accessing treatment through public health infrastructure

Those who are not so lucky may still be able to get treatment through other means. Public health care institutions are notorious for their inability to offer much in the way of services to the general population, much less those who are HIV positive, while private for-profit institutions treat those with HIV only as long as they can pay, at times with treatments of doubtful efficacy (chapter 7). The AIDS industry's efforts have neglected medical treatment for people with HIV, preferring to concentrate on prevention and, in a minority of cases, "cost-effective" interventions aimed at offering people with HIV "care and support." This entails supportive listening (as shown in Chapter 9) and home-based palliative care. The only exception to this rule was a UNAIDS initiative which attempted to make antiretrovirals available to poorer patients.

The UNAIDS initiative was a pilot programme co-ordinated by the agency to improve access to antiretrovirals — similar programs were launched in Uganda, Vietnam, and Chile. The agency hired a consulting firm to negotiate reduced prices for antiretrovirals with pharmaceuticals firms and implement a distribution system in the country. The Ivoirian government pledged one million dollars to a drug purchasing fund that would be used to subsidise the medicines. Interestingly, UNAIDS did not itself make any financial contribution to drug purchases, as this was "beyond their mandate" as a "co-ordinating and technical support agency."

The programme got underway in late 1998, recruiting patients at the Infectious Diseases Service of the Treichville University Hospital, one of the city's TB control clinics, and at a handful of NGO outreach sites. The program quickly became embroiled in controversy. Several hundred people were treated through the programme, although the subsidies were insufficient to allow them to keep paying for the drugs for more than a few months. Almost all of those who continued could only afford two drug cocktails. As a result, the majority became resistant to these drugs, as demonstrated by their CD4 counts, viral load measurements, and resistance testing done by the CDC's retrovirology lab in Abidjan. The laboratory data collected by CDC was compromised by the irregularity of follow-ups, which meant that blood specimens were collected at more or less random intervals, rendering any kind of meaningful epidemiological analysis difficult. Prescribing physicians, who had been selected from a variety of public health institutions across the city, had minimal training in using the drugs, limited to a three-day seminar conducted by a French AIDS NGO.

The selection criteria for subsidies were never made clear. One group of activists, that had been quite vocal at the Geneva AIDS Conference in 1998, received an unprecedented 95% discount and were able to afford the triple therapy cocktail with this subsidy. Curiously, the group ceased to be visible on the local AIDS scene at about that time. The co-ordinator of the program explained to me that the generous subsidy had been an administrative error. It was never clear what role the distribution system was to play, and the whole program became quickly mired in an ongoing corruption scandal that resulted in the suspension of European Union aid to the country (see chapter 6). It became clear that the prices

that had been negotiated by the consulting firm were in fact going market rates, and that as prices for antiretrovirals dropped through 2000 and 2001 the program was briefly locked into a higher price.

The 1999 coup complicated things even further. According to the incoming military government, outgoing officials had looted the Treasury and the state was near bankruptcy. The military government's evaluation was credible, given the financial track record of the previous government, and due to the fact that its Finance Minister was briefly detained the day after the coup in Amsterdam after alighting from a flight that had just arrived from Accra with several million dollars stuffed into two suitcases and a pistol. Arrears to the Public Health Pharmacy, which purchased the antiretrovirals, mounted to the point of compromising its ability to purchase other essential generic medicines. Discontinuations in ARV purchases ensued that, combined with poor inventory management, led to sustained interruptions of deliveries of antiretrovirals. Thus, throughout 2001, the supply has been patchy at best, meaning that almost all those on the UNAIDS programme had intermittent, partial therapy — a situation certain to generate drug resistance in all involved patients. While the situation was denounced, little could be done.

In retrospect, it seems that it was unreasonable to expect Abidjan's crumbling public health facilities to shoulder the burden of such an ambitious programme. Staff in hospitals and clinics complained that they were not compensated for the extra work that the programme entailed. Furthermore, it seems that, after launching the process, UNAIDS did not follow through as enthusiastically as it might have with technical support to monitor drug procurement and distribution, and training of physicians. Ultimately, the programme was less than a success because of the lack of resources that were devoted to it.

Treatment through research

Another exception to the widespread reluctance to address the issue of treatment for people with HIV in Africa is the Institute for Biomedical Research in Abidjan. It was founded in 1995 with the intention of treating people with HIV without outside help, and attracting clinical research to expand access to treatment to

those who could not afford even the cost of ARVs. Like *Jeunes sans frontières*, however, the Institute's drive stems from the charisma of one individual, and its therapeutic mission from that individual's experience with illness. However, in the case of the Institute, as will be shown, the ability to translate that experience into concrete resources for people with HIV in Africa derived from its founder's position in a well-placed social network that spanned Abidjan and Paris.

The Institute for Biomedical Research was generically named because, at the time of its creation in 1995, it was widely believed that any reference to AIDS would "frighten off" patients. It is the first official African institution dedicated to biomedical research on, treatment, and prevention of HIV/AIDS infection in West Africa. The Institute's efforts to appear dissociated from the epidemic so as to not stigmatise its patients were to no avail in the "big village" of Abidjan. As patients explained to me, furnishing a succinct definition of the epistemology of rumouring discussed in chapter 6, "if you know something, than everyone else knows it," or, "you know, in Africa, there are no secrets." Furthermore, the Institute was next door to the National Blood Bank that was home to what had become the Institute's rival, the "AIDS Fund." The rival had, in what Institute staff perceived as a hostile display, erected a huge billboard on the street displaying its name and logo. In a city where streets were constructed long after buildings and other public spaces, the Institute was known as the "behind the AIDS Foundation billboard," permanently associating the Institute with AIDS in the urban imaginary. This is significant because, by going there, patients were in effect "coming out" about being HIV positive.

Bertrand Dupont, a surgeon, is the Institute's founder, driving force and current director. He "caught HIV" sometime between 1980 and 1983, when he cut himself operating at the Treichville University Hospital. Its mission was to make treatment available in Abidjan. In that, it was the first institution in West Africa to concentrate on the issue of treating people with HIV openly, long before it became fashionable amongst international agencies, or before local groups realised that this was an issue at the very heart of their own survival. Dupont banked that there would be a market of paying patients who could keep the Institute running and that, if he could attract the research infrastructure he would then be able to use clinical trials to treat patients for free. As the son of prominent settlers he was able to access and mobilise networks of support in the metropole

and succeeded in getting a fully equipped lab. Dupont's "village" was the cosmopolitan sphere that linked Abidjan and Paris. Dupont's maverick style allowed him to scale networks and "go to the top," to mobilise resources. The Institute's laboratory facilities, as impressive as they are, are a less precious asset than its loyal cohort of patients.

It is widely believed that conducting clinical research in African settings is fraught with "cultural," as well as economic, barriers. African patients, it is often said not only by Western physicians and bureaucrats but by African physicians as well, are notoriously "noncompliant." Why? Because "they go to the witch doctor," because "they do not return for appointments," because "they stop their treatments when they feel better" are the common reasons given by African and Western clinicians and officials alike. This way in which efforts to improve patients' access to treatment is dismissed contrasts with the colonial period. Then, patients were more actively sought after — so much so that they were forcibly injected or were even interned for treatment. The colonial medical authorities' frustration with this kind of behaviour in the face of their well-meaning efforts led them to, at times, blame the natives' evasiveness on ignorance, irrational fears or even moral ineptness. Nowadays, frustrated physicians and public health officials — most of them African — resort to culturalist explanations, blaming patients' noncompliance on the ease with which they either resort to what is offered in "the village" or just stop coming back once they feel better.

The Institute's patients, however tell a different story. In the first year of the Institute's operation, over 900 patients consulted there — half of them came back — a retention rate considered to be excellent by clinical epidemiologists. Many don't return because the $7 consultation is expensive and, if they are poor, they are told only to come back if they are ill. Those for whom the registration fee was not an obstacle kept coming back regularly because they felt well treated — "the receptionist is always friendly," or, "the doctor explained things to me." Patients were appreciative that an effort was made to give them appointments rather than being just expected to turn up and wait, as is the case in the public sector. Rudeness, long waits, and "not being told anything" were patients' most common complaints about the welcome they received in public institutions. In these institutions, staff cite lack of time for not explaining things to patients, frequently adding that patients would not understand anyway. While this is often the case, I

found that a fear also exists that by explaining and demystifying medical knowledge, practitioners will lose some of their status and prestige.

Considering it normal for staff to barely speak to patients ("treating them like animals" commented one physician, who had left the public service), makes it easier to blame patients for not complying with medical treatment. Dupont, while at times perfunctory in his explanations to his patients, instilled a culture of explanation at the Institute that had served him well in building up his private practice. His almost abrupt familiarity reassured patients, as did his popular ways of "acting like everyone's brother" as some put it. He succeeded in dissolving the hierarchy that normally separates patients from physicians.

Dupont's patients returned to him even after news of his diagnosis wound its way through the grapevine, as they were already a loyal clientèle. There is no doubt that this also encouraged HIV positive patients to come to him. After his diagnosis, he took particular interest in treating people with HIV, and was certainly the first physician in the country to openly counsel and test his patients. Being himself HIV-positive, he was also keenly aware of treatment issues and up to date on the indications and use of antiretrovirals before they became available in Côte-d'Ivoire. Sure enough, word got around, and the sheer volume of Dupont's AIDS practice weighed in heavily in the decision to set up the Institute which, Dupont thought, could function as the "research arm" of his private practice. Indeed, many of Dupont's patients left the homey feel of the family practice in the leafy colonial district of the Plateau for the gleaming sterile quarters on a busy road across from a Peugeot dealership, behind the "AIDS Foundation" billboard. They did this first out of loyalty to Dupont and then because of the service they received there.

The first clinical trial was conducted at the Institute in 2000. Twenty patients were enrolled into a study where they all received triple therapy for HIV. These patients were representative of the Institute's patients — a few had good jobs, but most were poor. The study showed rates of adherence to follow-up superior to rates observed in Western settings, and that the most important determinants of adherence were economic. Patients were not paid to be in the study, and some had difficulty finding the money to travel to the Institute. The study also showed that the combination was biologically as effective as in Western patients.

Despite the Institute's relative isolation from the Western research world, and the difficulties of developing a culture of research this isolation entails, its loyal cohort of patients and laboratory infrastructure make it well positioned to take advantage of a growing market for clinical data. This raises an important question. Transnational socio-economic inequalities, and the gradients of disease and inequity in access to health care are associated with them, may unwittingly produce ideal conditions for the conduct of clinical research that furthers the marketing concerts of the pharmaceutical industry. Does the institute's drive to provide treatment through research not risk consolidating the market power of the social forces that make treatment inaccessible in the first place? While there is no clear answer to this difficult question, it underlines the importance of understanding the nature of the market power of the pharmaceutical industry. This will be explored below.

The market for pharmaceutical knowledge: clinical trials and the ethical problem

Clinical data is a cornerstone of the market power of the pharmaceuticals industry. Data from clinical research carried out in developing countries is becoming increasingly important to pharmaceutical firms. When the Institute opened in 1998, the pharmaceuticals industry was skittish about doing clinical research in developing countries. Merck's "035" study, conducted in Brazil, comparing triple therapy using AZT, 3TC and its drug Crixivan with treatment with only one of these drugs. The study generated controversy because some patients were kept on the single therapy arm of the study long after it had become accepted that triple therapy was better and was therefore the standard of treatment. Merck's experience, along with clinicians' suspicion of trials conducted in developed country settings, made companies skittish about pursuing such trials throughout the past decade.

Now, in 2001, the situation has changed. By the late nineties, the epidemic had slowed in the North, and patients who were not already on antiretrovirals were hard to find. But these "naïve" patients (so-called because they had never been treated with antiretrovirals) were extremely valuable for companies' marketing

needs. In order to create a market share for a new drug, a company must show that the drug is superior to standard treatment in clinical trials. By 1998, AZT-3TC-Crixivan was considered the standard against which all new drugs were to be judged. But, for virologic and pharmacologic reasons, most new drugs in the pipeline are unlikely to be significantly superior to this standard — they are "me-too" drugs whose mechanism of action is no different from existing treatments.

As a result, new drug combinations require large numbers of patients to be recruited into clinical trials in order that any small improvements in patients' clinical outcomes can be attributed to the drug's effect rather than to random variation in these outcomes. Since previous treatment with antiretrovirals attenuates the impact of subsequent drugs, the therapeutic impact of new drugs is much more likely to be seen in ARV-naïve patients. However recruitment of large numbers of previously untreated patients is difficult in the North — as a result, companies must conduct expensive multi-centre international trials that take years to recruit patients, delaying a drug's arrival on the market and increasing its research and development costs substantially.

With more and more new drugs — from three in 1994 to over 12 today — coming out of their development "pipelines," competition for suitable patients is fierce. This requires companies to recruit patients across a greater number of clinical research sites and to offer more generous inducements to these sites for recruiting such patients. The enormous expense implied by these clinical trials encourages companies to conduct trials with combinations of exclusively "in-house" drugs. If an "all-in-house" combination can be proven to be as effective as the best available treatment, all three drugs will generate profits for the company for the cost of one trial. For instance, GlaxoWellcome (now GlaxoSmithKline) strategically conducted a large international trial comparing three of its drugs (zidovudine, lamivudine, and abacavir) with two of its drugs plus Merck's indinavir, the "gold standard" of treatment. At the time the trial was designed and implemented (1997-1998), it was widely thought that HAART required a protease inhibitor to be effective, and GlaxoWellcome's abacavir was a nucleoside reverse transcriptase inhibitor, just like zidovudine and lamivudine. GlaxoWellcome "gambled," scientifically speaking, that any three drugs might be as good. The trial was a success, demonstrating that either combination was equivalent, setting the

stage for GlaxoSmithKline to dominate the market with a twice-a-day HAART cocktail, formulated in a single capsule.

Production of medicines is assured by private industry. Although pharmaceutical capital and production is concentrated in Europe and North America, and despite an unprecedented wave of mergers and corporate concentration, the industry is organised trans-nationally across regionally segmented markets and still remains fragmented with firms tending to specialise in a handful of therapeutic classes of drugs. Companies' market power does not derive from monopoly trading. For instance, GlaxoSmithKline, the largest firm world wide, only controls 7% of the market. Rather, it comes from the highly technical nature of pharmaceutical production and the industry's ability to exert control over raw materials and technological know-how, largely through intellectual property laws (see below). To this must be added the power of brand-names and a subtle array of marketing strategies. As shown above, design of pharmaceutical industry clinical research is one of those strategies.

Africa is where the majority of people with HIV currently live. It is also where there is the least treatment available. As a result, it is likely that Africa will become a prime site for clinical trials in the future. Performing clinical trials in developing countries is a growing trend, and raises disturbing questions about the link between global inequality and the market for scientific research. Frankly put, poverty and lack of access to health care means that the developing world is filled with sick and willing patients who are a goldmine for pharmaceuticals firms.

Biocapital: the pharmaceuticals industry, intellectual property and transnational activism

In America and Europe, an important goal of AIDS activism was to obtain treatment for the disease by lobbying for research and speeding up the regulatory process in order to get "drugs into bodies." The result was a blending of activism, clinical research, and medical practice (Epstein 1996). This allowed individuals to bypass standard drug procurement and distribution systems. Over a decade after the advent of this biomedical activism, the year 2000 marked a watershed in the global fight against AIDS and, arguably, in the

broader issue of globalisation and public health. What catalysed consciousness of the implications of global health inequities was the therapeutic revolution heralded by combination antiretroviral therapy.

It was in 1996 that awareness crystallised that the drug cocktails were going to let people with HIV *live*. At that time, the issue of treatment access in developing countries was almost unthinkable — the cocktails cost upwards of $15,000 annually, required complex monitoring, and were clearly out of reach for poor countries with per capita health budgets in the single figures. The issue began to surface in 1998 — as symbolised by that year's World AIDS Conference's slogan: "Bridging the gap," a timid acknowledge that "one world one hope" was certainly not the case. The decision to hold the 2000 conference in Durban, South Africa — the first time this conference had been held outside of a northern country — catalysed activists and media interest. Simultaneously, South African President Thabo Mbeki's public scepticism about whether HIV "caused" AIDS precipitated a media storm that focussed attention on the catastrophic dimensions of the epidemic in Africa in general, and in South Africa in particular.

The result has been unprecedented attention to the issue of access to HIV treatments and, increasingly, the state of public health in Africa and indeed throughout the developing world in this age of globalisation. This visibility has been largely due to the efforts of a transnational coalition of health and AIDS activist NGOs that have taken up the issue of access to HIV treatment in developing countries. This issue has resonated with broader concerns — and coalitions — that have sprung up around a plethora of issues posed by "globalisation."

Spearheaded by a professional and effective campaign led by *Médecins sans frontières*, *Health Action International*, and the *Consumer Project on Technology*, public, and political, attention has focussed on the prohibitive cost of these drugs (Stolberg 2001). These NGOs have been active advocates for equity in access to health for many years; however, the issue of lack of access to AIDS medicines gave them a high profile issue. Although AIDS activist groups in the north — such as ACT-UP — quickly rallied to the campaign, it is unclear why the issue did not emerge until fully five years after the therapeutic revolution

took place. ACT-UP Paris drew attention to the issue at the 1998 AIDS Conference in Geneva, but in this case the group's lack of professionalism and inability to back up rhetoric with solid policy probably undermined their credibility.

The increasingly professionalised NGOs of the AIDS industry, and multilateral organisations such as UNAIDS and WHO have belatedly joined the call for greater access to treatment. Privately, the emphasis on treatment worries AIDS NGOs. They believe that treatment is more expensive and may take away money from prevention efforts — an understandable concern as they compete for money from a fixed AIDS "pot." Multilateral organisations echo these concerns, although it would be surprising that they would take an activist role since they have historically been supportive of the international consensus on the protection of intellectual property and have consistently backed away from any measures that might threaten pharmaceutical industry profits (Peschard 2001).

As a result of the access-to-treatment campaign and the media attention it has drawn, there have been a chain of declarations announcing dramatic price reductions in the cost of these drugs. However, these only began once the Indian generics drugs manufacturer, CIPLA, offered to make the nine antiretrovirals it produces in India available at cost to African countries. Subsequent offers of price cuts by — in order — Merck, Bristol-Myers Squibb and GlaxoSmithKline, can be read as an attempt to protect their market share in the face of competition from generics. In fact, generic antiretrovirals are now being manufactured in Thailand and Brazil as well as in India. As a result, Brazil has been able to achieve similar public health benefits from combination therapy as western countries at a fraction of the cost. More worrisome for these companies, however, is the threat posed to their patents that they have been enforcing vigorously through international intellectual property conventions such as TRIPS, and lobbying of the US government to keep other nations in line.

The campaign on drug pricing has brought close scrutiny to the regulation of scientific knowledge by intellectual property law. The pharmaceutical industry produces and sells drugs that are themselves developed either "in-house" by the

research and development arms of pharmaceuticals firms or in public research laboratories most often housed in universities. The separation between "in-house" drug development and public research is in fact an artificial one, because even privately developed drugs rely on scientific research that has been publicly conducted. This has been forcefully pointed out in the last months.

The access-to-treatment campaign brought to the fore the role of international conventions and agreements governing intellectual property, and the institutional mechanisms by which these are enforced, in ensuring the profitability of the pharmaceutical industry. Recent attention has also focussed on patenting of the human genome and indigenous knowledge. While not strictly part of the process of drug production, this transnational institutional sphere nonetheless is an important part of bio-capitalist accumulation. These will be important issues that will shape whether, and under what conditions, Africans will obtain treatments for HIV infection.

Conclusion

The ways in which individuals gain access to treatment is conditioned by social, political and economic relations. These relations can be thought of as networks that extend from the bodies of afflicted individuals to the sites of drug production. These networks scale relations of different magnitude. For individuals, social relations comprise the social networks — kinship, friends, voluntary associations — of everyday life. These are "face-to-face" networks.

Between these everyday social relations and sites of pharmaceutical production lies a patchwork of institutions that mediate the "life cycle" of medicines that lies between "birth" (production) and "death" (consumption). This patchwork comprises private neighbourhood pharmacies, pharmacies in public hospitals, drug wholesalers and distributors, whether at the local, national, regional, or international level, and regulatory agencies (van der Geest 1997).

In many northern countries, national health insurance has meant that citizenship automatically confers access to treatment. This is obviously not the case in developing countries. In its place, individuals must draw on their financial capital

or, as is the case for the vast majority who cannot afford medicines, on their social capital to pay for drugs. Social capital, in this case, designates the proximal network of social relations through which resources may be mobilised. These resources may be material, or social. Material resources may be used directly to pay for drugs, or they may be used to invest in businesses that will generate revenues to cover the cost of procuring drugs. In the latter case, one's social network can be used to obtain introductions to individuals — such as physicians or politically powerful figures — who may be able to help access drugs.

Individuals also make use of social networks to mobilise the resources they need to purchase medicines or gain access to sites where these are available. These sites may be public health facilities, research institutes, or NGOs. At these sites, drugs may be available at lower cost than in the private sector, or may be completely free, as in the case of research protocols. Social networks may also channel treatments directly to affected individuals. This is when relatives, friends, colleagues, or fellow activists in Northern countries with access to drugs send medicines to individuals or institutions in countries with limited access. As this process has become more widespread, the term "drug recycling" has been adopted to describe it.

The ability of individuals to leverage social relations to get themselves into treatments, however, is constrained by the political economy of the transnational pharmaceuticals industry and, behind it, the global organisation of capitalist production. Transnational advocacy groups appear to have achieved some success in pointing out, and reducing, these structural barriers to treatments, but it remains to be seen how sustained these will be.

Treatments influence biology and therefore representations of the disease, and the subjectivity of those who are able to access them. One result has been the advent of a therapeutic activism spearheaded by those who have had access to treatment on behalf of those who do not. This concatenation of biology (epidemics and the therapeutic effect of drugs) and social relations (those that condition the spread of epidemics and those that condition access to treatments) is an example of biosocial change. The biosocial changes brought by the epidemic has begun to crystallize in a notion of "therapeutic citizenship." Therapeutic citizenship is emerging as a salient force in the local

African settings that have been explored here, where widespread poverty means that neither kinship nor a hollowed-out state can offer guarantees against the vicissitudes of life. It has also emerged as a rallying point for transnational activism in a neo-liberal world where illness claims carry more weight than those based on poverty, injustice, or structural violence.

Conclusion

This consideration of Abidjan's HIV epidemic in historical, sociological and ethnographic perspective allows me to return to the issues raised at the beginning of this dissertation. Practically, I asked why efforts to control the epidemic and TO attend to those it has afflicted have been, at best mitigated. Theoretically, I asked how we might BEST conceptualise the relationship between biological and social change. After examining body of existing scholarship that has pointed to the role of social inequality in determining differential outcomes in health, the importance of globalisation to understanding social change in the contemporary world, and the increasing role of biomedical knowledge in shaping the way we understand ourselves and the world it was clear to me that these questions needed to be asked.

As has been shown in this thesis, simple explanations that attribute the extent of the epidemic in Abidjan to culture, sexual behaviour, or timing are unsatisfying at best and misleading at worst. In comparative perspective, it is difficult to isolate any one variable that could explain why the West African HIV epidemic's epicentre is in Abidjan. The historical and sociological evidence reviewed in this dissertation argues against simple determinisms, and for greater complexity. As has been shown, [the] colonial struggles and mediating strategies [laid] furnished the elements through which later forms of collective and individual agency would be articulated. Rather than appeal to deterministic models, this evidence demonstrates how locally entangled biological and social contingencies "crystallised" the epidemic.

Understanding complexity requires accounting for how broad structural forces that impose constraints from above articulate with local conditions. These broad structural forces are political economy, state power, and geopolitical struggles over territorial power. Globalisation has shifted the configuration of these social forces, resulting in A heightened economic vulnerability of populations who live

in countries with weak states and structurally dependent economies. At the same time, cultural globalisation has disseminated the promises of modernity and, more significantly, the promises of therapeutic modernity. In a world where the poor are increasingly ill, awareness of the potential of biomedicine to treat the majority of the afflictions from which they suffer has never been so acute. This drives resort to biomedicine even though it must be accessed at great cost. Paradoxically, poverty creates a market for biomedicines as the sick seek out therapy. This market is supported by humanitarian agencies who intervene in the spaces left vacant by weakened states and, increasingly, by the need for clinical research in Northern countries.

Inequalities in the distribution of illness conjugate with inequalities in access to therapy to produce an increasingly diverse epidemiological landscape. The emergence, or re-emergence, of infectious diseases as a serious threat to public health is symptomatic of these conjugated inequalities that create biological and social gradients along which pathogens, and interventions to combat them, may travel. For instance, drug-resistant organisms may spread from areas with better access to biomedicine to areas with poorer access; alternatively, the transmission of new organisms may be amplified by biomedical practices that attempt to address existing public health problems.

Thus, while structural forces — the state, international institutions, capitalism — constrain material options, they also furnish the tools that individuals use to act upon their social and biological environment. The manner in which these tools are employed derives from peoples' understanding of their place in the world as well as their embodied experience of the world. The tactical and pragmatic way in which individuals mobilise these understandings and their experience, I argue, constitutes the cultural dimension that is so important to understanding how local contingencies shape these entanglements of biological and social phenomena. Significantly, what is at stake in these "local biologies" is access to material resources and, eventually, therapy. The notion of "biosociality" also connotes the merging of the biological and the social, although in its original use (Rabinow 1991) the term referred to the organisation of social communities around a biological category. Evidence presented here suggests that biological categories may play a role in organising social relations, but only to the extent that these are articulated at some level with strategies for addressing immediate material needs.

As a result, I have preferred to adopt the term "therapeutic citizenship" to describe how people with HIV translate their biological condition into social and biological change by advancing claims to therapy.

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