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The colonial landscape of development and health**

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New missionaries, old crimes? The colonial landscape of development and health.

Paddy Rawlinson¹

Abstract

The article examines how, despite the rhetoric of altruism, aid and progress the outcome of many development programs in the field of health is the creation of sites of extraction for the health and wealth of the global north, operating as a contemporary form of colonialism. It argues that violence is bound up in the epistemological foundations of western medicine and health, hidden by scientific claims to objectivity and what might be termed crude utilitarianism, that is, on claims of western medicine and health as the value-free striving for the biophysical and psychological betterment of humankind. Exacerbating the propensity for violence, by broadening its reach and intensifying its presence, is the criminogenic environment nurtured by neoliberal models of health delivery. Thus, in health promotion and policy, often well-intentioned and not without its benefits, lies the propensity and actuality of transforming health and healing into their opposite: injury and death, perpetrated through the very discourses and mechanisms meant to prevent them.

Key words: Development, violence, rent-seeking, health

Introduction

A growing number of criminologists from the global north,² in particular those from post-colonial states, (Carrington *et al*, 2015; Cunneen, 2011; Blagg, 2008; Braithwaite *et al*, 2010) have called for a greater focus on crimes of empire and

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² Rather than putting them in inverted commas throughout, the use of the terms global north and global south, developed and developing are used for the sake of simplicity, in the knowledge that they have been constructed from a Western perspective and therefore carry implicit meanings which are not necessarily those to which I subscribe.

their post-colonial legacy, crimes which appear to have slipped under the radar of criminological concern. The call is an important reminder that history demands constant scrutiny, not only from historians but from those in other disciplines who might offer different perspectives, raise unasked questions and provoke theoretical considerations beyond the familiar historical paradigm. Reassessing past deeds through a criminological and human rights lens (Short, 2014) allows us a greater understanding of the repercussions of imperial violence in its contemporary social, political and economic manifestations. For the past is not always 'a foreign country', nor do they necessarily 'do things differently there'. Historical elisions, obscured by hegemonic narratives and discursive practices that confine wrongdoing to a particular time, space and place, expediently disconnect the present from the past, speaking of transgressions as if they 'were', rather than 'continue to be'. Underlying these narratives is the assumption that a moral rupture exists between the rapacity of the colonial past and the numerous current initiatives that seek, in principle, to do the opposite, as in the diverse programs directed towards the so-called 'global south' for what is termed 'development'. In other words, we are now led to believe that the rent-seeking and racial brutalities of empire have been replaced by the more philanthropic, altruistic gaze of the global north, in a reverse trend of sharing rather than appropriating, cooperating with rather than dominating. On this understanding, development programs have been conceived.

Some post-colonial critics offer a different reality (Escobar, 1995; Rist, 2014). Scrutinising the larger context of development programs such as the United Nations Millennium Development Goals (MDG) and its successor the Sustainable Development Goals (SDG), they see a continuation of the imperial impulses of the old colonialism, the manifestation of more subtle forms of dominance and control. Violence is less explicit but no less common. In the words of dependency theorist Samir Amin, development programs such as the MDG amount to little more than 'pulling the wool over the eyes of those who are being forced to accept the dictates of liberalism in the service of the quite particular and exclusive interests of dominant globalized capital' (2006). In other words, behind the altruistic tones of the Goals, rent-seeking remains a driving force, manifesting through agendas conceived within the global north which effectively serve its interests over those of the targeted population.

Health, as a major part of the development program, is no exception. Delivered primarily through Goals 3 to 6 of the MDG with an agenda 'to ensure health and well-being for all, at every stage of life' which prioritises

‘reproductive, maternal and child health; communicable, non-communicable and environmental diseases; universal health coverage; and access for all to safe, effective, quality and affordable medicines and vaccines’ (United Nations, 2017), the global north has effectively laid down the terms Health and the body are socially and culturally defined (Lupton, 2012), diverse in meaning, fluid and geographically discrete. Yet development initiatives, while acknowledging social diversity in its myriad forms, appear to pay little heed, or perhaps more accurately, attribute different values, to diversity as it manifests in the various attitudes to the body, to life and death and the manifold forms of healing and conditions under which the body, health and healing are to be defined. Western health and medical concepts and practices drive a global health agenda, claiming their dominant status on the basis of scientific reliability, while derisively writing off local and cultural alternatives as a ‘fetish, primitive, witchcraft, diabolical and unscientific’ (Etope and Etope, 2013: 23). Priorities often are given to diseases regarded as problematic in the global north, such as measles or polio, while illnesses emerging in specific locales within the global south, as occurred with Ebola (see below), are ignored until they become a risk to the developed world. While health issues are understood within a broader framework, as in the need to develop functioning infrastructures including the provision of clean water, improved sanitation, educational programs around health and hygiene, and so on, the political and economic factors impacting on health, for example, pollution, exploitative employment practices, continuing land clearances for mineral extraction, civil conflict to name but a few, tend to be understood as local issues rather than the negative consequences of neoliberal globalisation, and the continuing failure of decades of aid and development. More recently, with the increasing influence of philanthrocapitalism³ as a major source of global health funding, powerful unelected, and thus politically accountable bodies such as the Bill and Melinda Gates Foundation, operate as key determinants in prioritising the what, where and how of health delivery to the global south. Criticisms that they function out of and for the ‘exclusive interests of dominant globalized capital’ in the pursuit of the arbitrary designs of the sponsors, reflect growing concerns that independent bodies such as the World Health Organisation (WHO) have become little more than conduits for what McGoey terms ‘donor darling’ projects (2015).

³ Philanthrocapitalism describes a model for social entrepreneurship which uses the market model to engage philanthropy as a more effective and influential activity.

Many of these agendas and practices amount to a form of rent-seeking, that is, the promotion of the interests of one group, at the expense of another within the sphere of political economy. Rent-seeking, a key component of empire-building, involves the violent exploitation and appropriation of resources, be they human or material. As the article will argue, rent-seeking is evident in various aspects of health and development agendas, violence in diverse and nuanced forms as a continuity of colonial practices.

The article focuses on two particular aspects of violence related to the rent-seeking proclivities of development. It argues that violence is bound up in the epistemological foundations of western medicine and health, hidden by scientific claims to objectivity and what might be termed crude utilitarianism, that is, on claims of western medicine and health as the value-free striving for the biophysical and psychological betterment of humankind. Exacerbating the propensity for violence, by broadening its reach and intensifying its presence, is the criminogenic environment nurtured by neoliberal models of health delivery. In other words, the commodification of bodies and health inevitably leads to exploitation, especially of the most vulnerable. Thus, behind the rhetoric of altruism, aid and progress lie economic, epistemological and moral tyrannies which engage the bodies of those in 'developing countries' as sites of extraction for the health and wealth of the global north. In other words, in health promotion and policy, often well-intentioned and not without its benefits, lies the propensity and actuality of transforming health and healing into their opposite: injury and death, perpetrated through the very discourses and mechanisms meant to prevent them.

Violence, disease and medical research

MDG and SDG health programmes are largely based on the monistic, reductive materialist framing of the body, disease and medicine in which technologies of health, emerging from this epistemology, have become the dominant means of understanding and responding to the prevention and cure of disease. Connell warns that to challenge Western epistemologies, inevitably leads to 'to problems *about knowledge itself*, for these analyses do not generally arise, and are not comfortably contained within, the knowledge structures of the global metropole' (Connell, 2013). Subverting the epistemology of western medical science is especially challenging in the current climate of medicalisation, the seeping of the medical into the political, social, and economics of every life. To critique it as permanently teetering on and displaying of acts of violence might

seem counterintuitive unless considered from outside the scientific rationalism that defines 'common-sense'. Critical voices from the post-colonial space are particularly adept at rattling the cage of western epistemological certainty, in their occupation of multiple knowledge locations - those of the West, and their own native knowledge locales which simultaneously assimilate, adapt and resist the hegemonic positioning of western thinking (Nandy, 1988).

Consider the account of two Indian intellectuals and physicians Kothari and Mehta, whose outsider-insider gaze detects not only the ubiquity of violence in medical research but the almost ineluctable path towards its expansion:

At medical conferences, papers written with the blood of tens of thousands of experimental animals are deliberated upon...Neither William Blake's maxim that 'everything that lives is holy, life delights in life', nor the Vedic message *isavasyam idam sarvam* (God permeates everything) is ever made known to medical persons. The outcome is that in trying to do good to man by doing harm to animals, the doctor loses the art of hearing the cries of suffering animals. And once he gets used to ignoring a dis-eased animal, as Solzhenitsyn seems to recognise in his Cancer Ward, he learns not to listen to a dis-eased human being'. (1988: 66)

Theirs is not just a commentary on medicine *per se*, but of the philosophy of life itself, the nature of corporeality and the subjectivity of scientific endeavour in its hierarchising of lives according to constructed value systems. Referencing social outsiders (Blake was described by one critic as 'an unfortunate lunatic', Solzhenitsyn incarcerated for his anti-Stalinist views) they critique from the 'irrational' standpoint of an alternative epistemology. This is not simply an anti-vivisectionist line, but a commentary on the ontology of the body and the consequent processes involved in healing.

The procedural violence of scientific aspirations, encapsulated in the pursuit of the ultimate goal to create life itself, is one of the issues that shaped the dark narrative of Mary Shelley's nineteenth century gothic novel *Frankenstein*. Beyond the murderous rampage of Frankenstein's monster (so beloved of Hollywood), Shelley (another outlier), like Kothari and Mehta, recognised the dangers of scientific myopia, even in the noble pursuit to 'banish diseases from the human frame'. Recounting, in despair, his own murderous journey towards the successful completion of his definitive experiment, her protagonist describes the brutal insensitivity that accompanied, and indeed enabled his work: 'Who shall conceive the horrors of my secret toil as I dabbled among the unhallowed damps of the grave, or tortured the living animal to animate lifeless

clay' (1992: 55). Others too, notably women, saw the barbarism of scientific objectivity and utilitarian justifications for the mass killing of animals, leading to the foundation of the world's first national anti-vivisection society by Frances Power Cobbe in 1875.

The Janus-nature of western medicine, less visible in its destructive capacities than other forms of scientific and technological advance, nonetheless demonstrates the fraught relationship between doing good, bettering humankind, with the brutal and brutalising path towards that admirable goal. Bauman's sociological analysis of the Holocaust lays before us the uncomfortable reality that the Holocaust itself could not have occurred but for the presence and manipulation of scientific rationalist thinking, technological development and bureaucratic organisation as the defining constituents of modern civilisation. That reality, as he states, comes down to the fact that 'the Holocaust could merely have uncovered another face of the same modern society whose other, more familiar, face we so admire' (1988: 7). And if, as he claims, the Holocaust is 'the test of modernity' (*ibid*: 6) then one of the most effective tools of that test in the accomplishment of its goals, was medical science. Nils Christie too affirms the role of western medical thinking as 'another essential condition for doing the unthinkable' reminding us that:

amongst those sent to concentration camps to die from the brutalities of daily life or directed straight into the gas chambers, it was the doctors who met them at the genocidal endpoint of their rail journey, who assessed their physical capabilities and health, for work or extermination: Without doctors, or those close to them, on the platform, it would have been killing (2000: 189).

However, it was the racial underscoring of Nazi medical atrocities (with the exception of the eugenically motivated euthanizing of the mentally and physically disabled) that shocked and incensed, the cold transformation of human subjects into objects, a process determined by a so-called value-free scientific taxonomy in which race became the value-laden ordering of hierarchy.

This process of objectifying began with the scientific identification and classification of the biophysical, the understanding of what it means to be human by 'reading' the body. In categorising humankind as a species, which occurred in Western societies around the eighteenth and nineteenth centuries, it was possible to segregate groups of people according to physical attributes and place them within discrete, normatively-based classifications. Scientific classifications involved sweeping demographic generalisations about which groups, rather than individuals, were more likely to engage in certain

behaviours, demonstrate diverse levels of moral and intellectual capacities, or be susceptible to different types of disease. Crucially, this deindividualizing process involved a radical turn in the thinking behind health and medical practice, which removed the individual as the main focus, and placed disease at the centre of the medical gaze (Foucault, 1994). In doing so, the patient stood behind the disease, so to speak, becoming the site of disease manifestation, which was common to all bodies showing similar symptoms. Consequently, treatments would no longer take into account the humours that differentiated one patient from another, where temperament, mood and particular personal traits impacted on the illness, demanding a discrete medical response. Instead, what worked for one should work for all. Health could now be conceptualised in terms of the masses, of populations and in doing so, brought medicine and the state increasingly closer. In other words, health became politicised, a mechanism of control over life, in Foucault's terms biopower (2004) and public health, in the promotion of a physically active and productive industrial labour force, the mainstay of nation-and empire-building.

Developing biopolitical strategies for nation-building was central to Nazi policy. Through the objectification, deindividualization and politicisation of the body it was possible to remove the moral sting from the mass murders and provide a discursive distraction away from the humanity of the groups such as the Jews and Roma, through the employment of the disease metaphor. Representing them as a race and population of contagion, as *untermensch* or subhuman, their eradication through the efficient, scientific and technological means that medicine might deploy to destroy dangerous bacteria or viruses, was a logical response. So too in the 'necromethodology' of medical research, entailing as Frankenstein noted, that 'To examine the causes of life, we must first have recourse to death', human bodies (dead, dying or alive) became essential for the improvement of health, albeit to a discerned population. The basis for much of medical research, it was a small step to rationalize the torture and killing of the Jews and Roma⁴ as the pursuit of scientific advance, one of the justifications presented at the Nazi doctors' trials by the defendants, further rationalized by the belief that the role of the scientific researcher was value-free and could not be assessed as racially inclined. In his analysis of the doctors' trial Caplan concluded that, 'most of those who participated [in human experiments] did so because they believed it was the right thing to do' (2008: 65). It was convenient for the medical horrors revealed during the Nuremberg Trials to be

⁴ Amongst the victims were many Russians and Poles, groups often neglected in the narratives of Nazi medical atrocities.

isolated as aberrations, confined to the homicidally-inclined ideology of fascism, with the implicit understanding that, as Rose and Rose cynically note, 'research carried out in a democratic country was by definition ethical' (2014: 97). Yet, neither prior to, nor significantly, after the Nuremberg trials, which instigated the eponymous Code for ethical conduct in human experiments, was modern medical research and medicine and health devoid of its thanatic properties and practices in western states, not least in linking disease, criminality and racial inferiority through biologically deterministic theories. Nowhere was this more evident than in colonialization.

Colonising Health

Alvares argues that the very notion of colonisation is inextricably bound up with the scientific, insofar as 'A civilization driven by a theory of science/machine ipso facto becomes a colonizing force, and aspires to bring under its sway every other culture that has based its survival on a natural relationship with its surroundings' (Alvares, 1992:n.d). Science, in other words, is incapable of accepting a pluralistic epistemological worldview, one in which it can reach a *modus vivendi* with other competing epistemologies. Thus, colonialism was an exercise in scientific-political expansionism, replete with biopolitical constructions and repressions of the colonised 'other'. Science had 'proved' the racial superiority of the 'civilised' European, according to the theory of evolutionary progression, which formed the basis of Lombroso's *L'Uomo delinquent*, published in 1876, and his espousal of the genetically determined criminal. Deducing that physiognomy provided the key to detecting the 'criminaloid', it was hardly surprising that Lombroso's criminal types resembled 'savages' and 'backward' peoples of the colonised world. This was by no means a new perspective, having provided the basis for the Criminal Tribes Act, passed in India in 1871, a draconian piece of legislation that restricted the movement of certain ethnic groups deemed criminal. The groups targeted, according to Fitzjames Stephen responsible for helping to draw up the legislation, were those tribes 'whose ancestors were criminal from time immemorial, who are themselves destined by the usages of caste, to commit crime, and whose descendants will be offenders against the law, until the whole tribe is exterminated or accounted for' (Cole, 2002:67).

If they had not yet acquired the sophisticated technology available to twentieth century advocates of racial extermination, the empire builders of the seventeenth to nineteenth centuries were still able to entertain, and in some

cases, perpetrate genocidal responses to whole groups or castes designated biologically inferior.

Empire building is inextricably bound up with health and disease which function both as facilitators of imperialist expansionism and as threats to the process of colonisation itself. Hence, western medical science became pivotal to the success of empire. The growing armoury of health technologies and statistical narratives that came to define health and medicine in the industrial West, also became inculcated into colonisation. Medics were as crucial empire as missionaries and mandarins. Disease, though, was a two-edged sword working for and against colonisation as the immune systems of the colonisers and colonised struggled to cope with a range of illnesses to which their bodies had few, or no, forms of resistance. Local sicknesses, such as malaria and dengue fever, took their toll on the imperialists unused to the different climates and lacking the appropriate medical knowledge to deal with 'exotic' diseases. However, it was the indigenous people who suffered the most, faced not only with superior military skills and technologies of their oppressors, but the deadly array of sicknesses the latter brought with them. So effective was disease at hewing down the indigenous inhabitants of colonised lands of that it became *the* weapon of mass destruction, undermining heroic tales of conquest and technological dominance (Harding, 2008: 43).

The historian Eric Wolf refers to the pathogenic annihilation of local populations in the colonised lands of the Americas as the 'Great Dying', with measles and smallpox as some of the worst killers (Wolf, 1997). Some of the colonisers noting the efficiency of disease in exacting land clearances, considered strategically employing pathogens to eradicate indigenous opposition, in what might be described as the first conceptualisation of primitive biological warfare. Smallpox ridden blankets were allegedly 'donated' to North America Indians, with similar incidents claimed to have occurred in Australia against the Aborigines⁵. Irrespective of intention or accident, outbreaks of 'foreign' disease amongst indigenous groups helped to legitimise and ameliorate the introduction and imposition of Western medicine and technologies as the most effective means of treating not just European, but all forms of sickness. The impact of western medical imperialism even went as far as constructing instinctively natural behaviour as a form of disease. Slaves who wished to escape their work and living conditions and attempted to run away

⁵ Disputes over the accuracy of whether there was a deliberate strategy to infect Indigenous people continue, though the evidence seems compelling that it probably did occur, though to what extent and with what impact remain contentious. (See Warren, 2007)

were diagnosed as suffering from ‘drapetomania’, an ‘ailment’ said to particularly affect those of a lazy disposition and ‘low intellectual capabilities’ (Rojas, 2016: 184). Hence, scientific medical explanations for reactions to exploitation and abuse further served to objectify victims in a dehumanising process that not only distracted attention away from the pathological violence of colonialism, but incarcerated the victims in a diagnostic taxonomy which they had no discursive ability to challenge or escape from.

The ascribed biological inferiority of the colonised body legitimised the violence replete in the harsh treatment both of the native and the land, of the right to destroy who and what was neither subservient nor useful to the interests of empire. Medical science as an instrument of empire-building enabled the conflation of the body politic with the politicised body as sites of despoliation and extraction. Especially ripe, in the literal as well as metaphorical sense, for the exertions of what might be termed biopatriarchy, the conceptualisation and management of the female body according to enlightenment-based medical scientific epistemologies (Rawlinson, 2016), was (and continues to be) the female body. Miller argues, that the sexual and reproductive capacity of the female body is central to ‘the basic purpose of the modern, biopolitical state [which] is after all to produce and reproduce populations’ (2007: 151). Empire-building, as with the maintenance of the state, is also located in the womb as a political space, but one in which power manifests in discriminate ways, especially where health is concerned. This was evident in the provision of medication to local Malay prostitutes to cure venereal disease, a supposed philanthropic gesture but one which had the ultimate aim of protecting their clients, the male colonisers on whom the running of the colony was dependent (Mandelson, 1997). Crucially, though, keeping male colonisers disease-free was a political necessity, for this in turn protected their spouses in whose reproductive capabilities lay the future of empire (McClintock, 1995).

Thus, through in biopolitical, with its surgical dissection of peoples into racialised, gendered, intellectual and culturally normative categories, where bodies of utility were permitted life, and those deemed superfluous or threatening, denied it, colonialism was established and maintained. So too, Western medicine, in constantly reasserting its authoritative status through the epistemologies of its own making (for any other source of medical knowledge was primitive and bound to fail) was able to configure its violence as enlightenment, as an act of beneficence. The present, it turns out, is not such a different place.

Development as Violence

Development has now begun to take over from old-style religious conflicts, colonial wars and racism; it has created new opportunities for a play of those traits that once found expression (in) standardized channels and justifications of human violence. (Nandy, 1995: 8)

It was US president, Harry S. Truman, who first used the word ‘development’, incorporating it into policy—speak, to describe, or more accurately, inscribe, a world divided into two: those who enjoyed benefits accrued from the advances made in science and technology, in democratic states (of which the US was the shining beacon) and the ‘underdeveloped’ world, ‘handicapped’ by poverty, ‘victims of disease’ whose ‘economic life is primitive and stagnant’ (Truman, 1949). These plans, he reassured, would not be a return to ‘The old imperialism-exploitation for foreign profit’ but rather a democratic transference of scientific and technological knowledge which would increase productivity, the core principle for development. The economic model for achieving this was, of course, capitalism, emphatically driven home in the broader context of Truman’s inaugural address which was to highlight the dangers of communism and call for an international response, led by the US. Hence, the battle against poverty and disease would be won through Western scientific, technological know-how supported by the economic paradigm which had delivered its fruits to the developed world.

Bathed in the rhetoric of altruism, that would administer to the ‘least fortunate’ rather than the ‘savage’, nonetheless the tenor of colonialism was, and continues to be, unmistakably present. International development programs in their various iterations, act as moral entry points into decolonialised spaces as a means of pursuing the interests of the West, legitimised by the human rights discourse within which they are framed. Development is ‘a project through which an aggressive expanding class seeks to expand its control and use of other people’s resources and to neutralize any opposition to such programmes’, a mode of rent-seeking ‘intimately secured and supported by international capital, conceived and executed in the interest of the designers of the project’ (Alvares, 1992: 94-5). Health and the body are particularly vigorous areas for rent-seeking, sites of knowledge extraction and consumption.

The developing world, as regions of disease susceptibility has become one of the biggest potential markets in a burgeoning global health industry. Beset by high mortality rates from Malaria, HIV, childbirth complications, to name but a few, Western medical technologies, including vigorous immunization programs, have become the dominant mechanisms of health care. Integrated into SDG 3, is the Global Vaccine Action Plan under 'The leadership of the Bill & Melinda Gates Foundation, GAVI Alliance, UNICEF, United States National Institute of Allergies and Infectious Diseases and WHO' (WHO, 2013), with its ultimate target of worldwide vaccine coverage for a growing number of diseases. Clearly, this is a huge and admirable push for health improvement in the developing world, however, within the political economy of global health, it also reflects Alvares' concern with rent-seeking propensities, given the vast financial benefits to be harvested from the programs by one of the most powerful and influential industries, and one continuously beset by corruption scandals. The bounty, according to a WHO senior advisor and health economist, is potentially huge. It is projected that by 2025 the market for vaccines will be US 100 billion dollars, as they become 'an engine for the pharmaceutical industry'. This industry currently comprises five multinational companies accounting for 80% of vaccine production (Kaddar, 2013). Accelerating income potential and oligarchic structures of health governance betray the rent seeking behaviours of the colonial past. Multinational industries, working with and through intergovernmental agencies, colonise national and local health schemes creating self-sustaining frameworks of supply and demand which leads to an increasing erosion of autonomy in matters of health and other social areas, so that 'the only initiative the person is left with amounts to choices from among available consumables offered by the global market. From health care to child rearing it is the same story' (Nandy, 1995: 5). The economic calculus dominating development initiatives in the global neoliberalising of welfare together with an almost unshakeable faith in scientific monism, which feeds into and from this calculus, is obscured by an almost imperceptible translation of colonial domination into the discourse of democratic participation:

The postcolonial agenda has *integration* as its goal and its dominant metaphor. The universality of biomedical ways of knowing and doing is taken for granted, and achieving 'global health' depends upon integrating localities into global networks of commodity and information exchange" (King, 2002: 782)

Mired in this religious conviction of its unchallengeable status, Western medicine has become expediently amnesiac. In this forgetting it can engage in a complete volte while retaining its authority in scientific certainty. In January 2011, the WHO published a statement on research into the benefits of optimal breastfeeding as a means of providing children with the best nutritional care, protecting against gastrointestinal infections and lowering rates of infant morbidity. It notes: 'Over 820 000 children's lives could be saved every year among children under 5 years, if all children 0–23 months were optimally breastfed' (WHO, 2017). The factsheets scattered across the WHO website are largely dominated by photos of women from developing countries, an implicit and paternalizing reference to the continuing need to educate mothers from the poorer areas of the world. Yet, it was Western health and nutrition experts who, decades previously, espoused the virtues of bottle-feeding, encouraged by formula producers such as Nestle. Regarded as part of the modernising process, bottle feeding replaced natural, nutritious, convenient and safe activity in the belief that it offered more nutrients and helped reduce disease. Beyond the perceived health benefits, bottle-feeding also served the interests of growing economies, to enable 'the inclusion of female workers in the labour market, not only in industrial Western societies, but also in large-scale agricultural production in the colonies' (Sasson, 2016). However, as the deleterious effects of bottle-feeding became known, including obesity and heart disease, the Swiss food giant Nestle conducted an aggressive advertising campaign to maintain its sales to the Third World. It took a global grassroots boycott to halt the campaign as breastfeeding became reinstated as the best nutritional option.

Western medicine and health is replete with examples not just of dramatically changing opinions, but of harms arising from medial certainty, as in the discovery that the over-prescribing of antibiotics can lead to the consequent rise of 'superbugs', and growing evidence that the current obsession with pharmaceuticalised solutions for mental health issues results in a growing death toll from the use of antipsychotic drugs (Gotzsche 2015; Healy 2012; Goldacre 2010). In 2016, a study from John Hopkins University placed medical error as a third leading cause of death in the US, after cancer and heart attacks (Makary and Daniel, 2016), estimated at 98,000 deaths per year compared to 15,872 from homicide in 2014 (Kenneth et al, 2016). The brittle foundations upon which (medical) scientific certainty stands (Kuhn, 1996), its temporal quality, and susceptibility to the vagaries of the market is obfuscated by a self-confidence unwilling to be seriously questioned, the violence of which lurks behind a historical forgetting of gross incompetence and exploitation,

claims of arcane knowledge accessible to experts only, and the increasing conflation of health within domestic and international political-economic structures. The reluctance to attribute parity to medicine that does not fully, or only partially, concurs with the western scientific paradigm, such as Ayurveda in India, serves to even more deeply embed its hegemonic status in development health policies.

The distinguishing feature of modern medicine, as Foucault observed, is its embracing by the state, which in the current neoliberal order, involves the opening up of an economic space in which medicine and health must continually reside. Starting from the 'production of knowledge' itself (the phrase betrays the spatial capture) and its increasing attachment to economic utility to its dissemination and output, Western medicine, for all its benefits, cannot escape the commodifying process, affecting both its knowledge base and the target of this knowledge – the human body. In this economic paradigm, where the body becomes a site of extraction and consuming, a source of wealth for the biomedical mining of information as well as the purchaser of its products, violence is subtle, unseen almost, and humanitarian. Such is the nature of one of the fastest growing industries in developing world: clinical trials.

At the Gates of Heaven and Hell

Women's bodies are being redefined as 'factories' and 'mines' for pharmaceutical raw material. Indigenous communities find that their resources, knowledge and bodies are becoming raw material for the biotech industry and global trade (Shiva 1995: 280)

In the supply-demand dynamics of sickness and health, the burgeoning number of drugs we are told we need to consume, requires certain forms of regulation before they appear on the market. Clinical testing on humans is an essential part of the regulatory process, and one that by its very nature, comes with a level of risk. Risk in human experiments, as Nazi Germany, the Japanese Unit 731 and US Tuskegee trials demonstrated, is often ameliorated by the racial targeting of subjects (Lifton, 2000; Dickinson, 2008; Jones, 1993), or, as in the list of medical human rights abuses on conducted on human subjects after the Nuremberg Code, by targeting other socially vulnerable groups including those from low socioeconomic backgrounds and with mental or physical disabilities (Rothman and Rothman 1984). Clinical trials objectify the body, and thus transform them into commodities in a marketized environment. The migration of clinical trials followed a similar pattern to that of the migration of cheap labour, to those

areas that offered weak, or no regulation, either for the labour force or the quality of commodities, areas often *discouraged* from introducing appropriate legislation by the economic constraints they face within the global market. In the case of clinical trials, developing countries offer another advantage in the greater availability of naïve biomedical subjects, that is, those who have consumed few or no drugs, in contrast to their pill-popping Western counterparts, thus the likelihood of the trials yielding more accurate results (Petryana, 2009). However, in similar vein to the harms and deaths experienced by exploited workers in the factories across the developing world similar abusive practices are perpetrated against objects-subjects of the trials industry with little access to effective legal redress and adequate compensation. Difficulty in proving cause and effect in the myriad complexities of medical research, of locating legal responsibility amidst the sub-contractual arrangements between the pharmaceutical industry and contract research organisations, now responsible for a large number of clinical trials in the developing world (Mirowski and Horn, 2005), is further exacerbated by the moral framework within which health research rests. Claims to some form of ethical utilitarianism clearly helps to offset the unacceptability of violence, not least when clinical trials are championed by the philanthrocapitalist missionaries now in charge of saving the world.

After announcing a snap general election in 2017, the British Prime Minister, Teresa May hinted at a withdrawal from the commitment to spending 0.7 percent of the country's GDP on foreign aid. Almost immediately the billionaire philanthrocapitalist Bill Gates publicly criticised May's apparent stance, warning of 'consequences' should the government abandon its pledge (Wintour and Mason, 2017). Within days, May announced that the pledge would remain at the agreed 0.7. Whether Gates directly influenced the Prime Minister is uncertain, but the power and influence of his criticism is not. When Bill Gates speaks, the world listens. Listed as the wealthiest man on the planet (worth US \$75 billion, according to Forbes Magazine in 2017) Bill Gates, as the uber representative of philanthrocapitalism, and his Foundation, has become the stentorian voice of global development and health. Philanthrocapitalism, as an activity rather than nomenclature, is nothing new. For decades, the Rockefeller, Ford and Carnegie Foundations provided, and continue to, much-needed donations to facilitate the betterment of humankind according to enlightenment principles, succeeding in the creation of numerous worthy ventures. However, m/billionaire giving offers a convenient distraction away from the pertinent and uncomfortable questions as to how so much wealth can

accrue to so few, and what structural and ideological changes are required to unravel a system that encourages these levels of disparity. For Gates, however, as with his counterpart the Facebook founder Mark Zuckerberg who aims to ‘cure or manage all disease’ (*New York Times*, 2016) (an echo of Shelley’s Frankenstein’s aspiration to ‘banish diseases from the human frame’) the global reach of his ambition and influence invites a new form of power: unelected, unaccountable, often unchallenged and ubiquitous.

The Gates Foundation is not only one of the biggest contributors to the WHO’s global program, vaccinations, but one that plays a significant role in driving its policy direction, a course that is often dictated by the personal preferences of its founder. Gates pursues particular projects, nudging the WHO into following his lead, even when they might not be in the best interests of those they purport to help. According to McGoey, his almost obsessive goal to eradicate polio has directed funds away from more pressing and relevant diseases in regions that do not regard polio as a high priority, as well as ‘maybe fomenting unexpected health risks, such as exposing children to multiple polio vaccinations in areas where record-keeping is poor’ (2015: 155). Arundhati Roy voices concerns over the detrimental impact Gates and his supporters are having on feminist activism, as it sweeps in liberal feminists espousing the paradigm of Western health while silencing the voices of the post-colonial ‘subaltern’: ‘The funding briefs of NGOs now prescribe what counts as women’s “issues” and what doesn’t’, a reference to the marginalisation of post-colonial feminist movements as their Western liberal counterparts, which subscribe to the neoliberal values that underpin NGOs such as the Gate’s Foundation, become ‘standard bearer(s) of what constitutes feminism’ (Roy 2015: 36). However, in the scandal around the HPV vaccine trials in India, the subaltern voice was heard eventually, and what it had to say about the violence of missionary health saviours was disturbing.

In 2009 the Programme for Appropriate Technology in Health (PATH), a Gates Foundation funded NGO committed to accelerating the use of vaccines in low income countries, launched a Phase V clinical trial for the HPV vaccine in Andhra Pradesh and Gujarat on approximately 24,000 adolescent girls. After the deaths of seven girls and emerging chronic health problems in over twelve hundred other participants Between 200 2010 under pressure from health activists and media coverage of the deaths of five girls and the consequent chronic health problems of over twelve hundred other participants, the Indian government terminated the research. Pressure for a thorough investigation of the deaths, injuries and trials came from the Saheli Women’s Resource Centre

and Gramya Resource Centre for Women, leading to the publication of a report in 2013 by the Parliamentary Standing Committee on Health and Family Welfare. Amongst their findings, the committee discovered gross violations of ethical guidelines by PATH and Indian health regulatory bodies in an attempt to obscure the real nature of the study which was ‘to generate evidence, data and arguments to support inclusion of HPV vaccines into India’s state-funded Universal Immunization Program’ (Parliament of India, 2013). This highly lucrative outcome was also pursued through trials conducted in other countries such as Uganda, Vietnam and Peru, leading the Committee to conclude ‘the unlimited market potential in the universal immunization programmes of the respective countries are all pointers to a well-planned scheme to commercially exploit a situation’. The ethical violations included not ensuring informed consent was properly given, when it was discovered that over five thousand consent forms had thumb impressions rather than signatures, indicating the illiteracy of the participants’ guardians, and the probability that they could not have understood what they were signing; no evidence of an adequate monitoring for severe adverse reactions to the vaccines; and the absence of a control group against which to measure the impact of the vaccine. Nor was the HPV vaccine deemed necessary in a country where cervical cancers rates are dropping (Roli, 2016), a statement confirmed by a rigorous, independent scrutiny of PATH’s data gathering procedures on the burden of cervical cancer in India, which concluded that ‘Neither the epidemiological evidence nor current cancer surveillance systems justify the general roll out of a HPV vaccination programme either in India or in the two states where PATH was conducting its research’ (Mattheij, Pollock & Brhlikova, 2012).⁶ PATH denies the series of allegations and suggestions in the report.

A former high-ranking WHO employee warned ‘Gates has created a ‘cartel’ with research leaders linked so closely that each has a vested interest to safeguard the work of others. The result is that obtaining ‘an independent view of scientific evidence ... is becoming increasingly difficult’ (Martens and Seitz 2015: 38). Oligarchic structures are not just donor-driven health and development machines but the very source of knowledge creation and knowledge corruption, harnessing the future within a technological vision inspired by the philanthropic inclinations of those colonising not just a country

⁶ This is not just the situation in India. A report conducted by Queen Mary, University of London and The Paracelsus Medical University in Salzburg concluded that the WHO’s recommendation for HPV vaccines in national immunisation schedules was ‘based on weak evidence’ and that ‘Data on long term efficacy are lacking’ S. Scharer et al, (2014) Efficacy of HPV vaccines: A Review of the Evidence used by the WHO, *Journal of Epidemiological Community Health*, 68, (Supp 1) A57

but the globe, whether Gates' vaccine-drive to eradicate polio or Zuckerberg's proposed investment of US \$600 million to create a biohub in US universities for the utopian pursuit of a disease-free world. Discussions, debates and research on the body, disease and health outside the epistemologies of modernity are slowly being destroyed by the creeping authoritarianism of health philanthropy, the voices of the few who have succeeded in wresting from a pathological political-economic system an over-abundance of privilege and power, a system whose violence, as Zizek reminds us, is invisible, as in 'the dark matter of physics' (Zizek, 2008), and the more violent for its imperceptibility.

Conclusion

The historian Rajeesh Kochhar wrote that during the colonial era, India became a laboratory for British science (Harding, 2008: 137-8), in which the bodies of its people were exploited in the irrepressible march of western (medical) science. In this rapacious extraction of knowledge and material wealth in the appropriation of bodies, land and labour, colonialism left its bloodied mark packaged as civilisation. Recognising violence as an intrinsic component of medical science is not to reject the latter, but to acknowledge and contain, the propensity for harm and in doing so open up dialogues with alternative epistemologies, worldviews and beliefs regarding the body, health and disease. Further, in this recognition comes the realisation that development making its claim as a break from the past, as an altruistically infused, democratic and pluralistic impulse leading towards a healthy and sustainable future for all, is more chimera than reality. Its track record tells a story, which, while offering some of the benefits it promises, nonetheless retains and threatens to intensify the violent exploitation and rent-seeking of the putative colonial past. Rist argues for the need to seek alternatives to development, which of course, requires seeking alternatives to the dominant paradigm of medical science. As he concludes, '*the idea is to invent new ways of living, between a modernisation that causes suffering yet offers some advantages and a tradition that may be a source of inspiration even with the knowledge that it cannot be revived*' (2014: 275). A mortified Frankenstein would agree.

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