



Forced removals embodied as tuberculosis



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ABSTRACT

South Africa has one of the worst tuberculosis burdens in the world. Several ecological forces have contributed to this, including high HIV prevalence; failing TB control strategies; crowded, poorly ventilated indoor environments—including the complex web of political and economic interests which produce them; the development of racial capitalism; and mining and migration. In the following study, we measure CO₂ levels in public transport to investigate the role extended commutes from peri-urban settlements to urban sites of work—a direct result of forced removals—potentially play in propagating the TB epidemic in Cape Town, South Africa.

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“My friends ... Circumstances ... render it impossible that you can flourish in the midst of a civilized community. You have but one remedy within your reach. And that is, to remove to the West ... And the sooner you do this, the sooner you will commence your career of improvement and prosperity.”
—Andrew Jackson (7th President of the United States), *To the Cherokee Tribe of Indians East of the Mississippi* (1835)

1. Introduction

With a yearly tuberculosis (TB) incidence of 834 cases per 100,000 people, South Africa has one of the worst TB burdens in the world (World Health Organization, 2015a). The number of TB cases reported in Cape Town alone (population 3.4 million) is more than three times the number of all TB cases reported in the United States, a country of more than 300 million people (Wood et al., 2011a). Furthermore, the rate of acquiring TB infection in Cape Town is

similar to that which existed in early 20th century Europe, prior to the advent of chemotherapy (Vynnycky and Fine, 1999; Wood et al., 2010). Several ecological forces have contributed to this, including high HIV prevalence (World Health Organization, 2009a); failing TB control strategies (Wood et al., 2011b); crowded, poorly ventilated indoor environments (Chapman and Dyerly, 1964)—including the complex web of political and economic interests which produce them (Farmer, 2000, 2005); the development of racial capitalism (Packard, 1989); and mining and migration (Stuckler et al., 2011).

One underexplored determinant has been forced removals, that is, the policies and often violent processes involved in the massive, state-sponsored displacement of people (almost all of them black) from one area to another in South Africa (Platzky and Walker, 1985). Starting well before *apartheid* with the Public Health Act of 1897, the Native Reserve Location Act of 1902, and the Native Urban Areas Act of 1923—and consolidated in the Group Areas Acts of the 1950's and 60's—forced removals uprooted millions of individuals from both developed urban and rural areas to underdeveloped and poorly resourced peri-urban and rural areas resulting in widespread poverty, disease, and starvation (Desmond, 1971; Platzky and Walker, 1985; Surplus People Project, 1983).

As Rebecca Saunders writes, forced removals instantiate “a contrived geography that ... forces thousands to travel as far as two

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hundred miles a day to and from work and to expend a quarter of their earnings on bus fares” (Saunders, 2003). In Cape Town, for example, hundreds of thousands of Africans, Coloureds, and Indians were forcibly relocated over a fifty-year period from the city limits to the Cape Flats (Fig. 1) (Platzky and Waler, 1985; South African History Online (SAHO), 2015).

For a paper presented at the 1982 University of Cape Town Medical Students’ Conference entitled *Consumption and Underconsumption: The Effects of Population Resettlement on the Spread of Tuberculosis*, Saul Dubow wrote,

Clearly, we have to accept as a first premise that TB is a social disease born out of and aggravated by poverty, malnutrition, overcrowding and stress. But if we are to make progress in our understanding of TB it is not sufficient merely to describe these social conditions. We have to explain them (Dubow, 1982).

The myriad ways in which social, political, and economic forces become embodied as pathology are often difficult to trace given the dearth of formal methods in mainstream epidemiology and other biomedical models of disease causality; however, over the past thirty years, social theorists have begun to offer critical analyses of

epidemic disease which interrogate how features of disease distribution are obscured by dominant analytic frameworks (Farmer, 1996; Fassin, 2002; Richardson et al., 2016; Scheper-Hughes and Lock, 1986; Scheper-Hughes, 1990).

In his seminal genealogy of the TB epidemic in South Africa, Randall Packard traced the effects of social policies and capital interests that coalesced to drive TB incidence among marginalized black populations. He concludes in the Epilogue, “In effect the municipal authorities, who for decades pushed the sick beyond the city limits and thereby sowed the seeds of TB infection in the surrounding black peri-urban and rural areas, are now having to reap the harvest of TB cases their exclusionary practices have produced” (Packard, 1989).

Paul Farmer provided another historically deep analysis of TB persistence in marginalized populations, tracing how poverty and structural violence both constrain individual agency and shape the physical environments that place people at risk (Farmer, 2001). Moreover, he has argued compellingly that public health programs which neglect discussions of racial injustice, political oppression, and health equity perpetuate this structural violence through analytic omission (Farmer et al., 2006). He thus promotes biosocial approaches to understanding and alleviating disease burdens

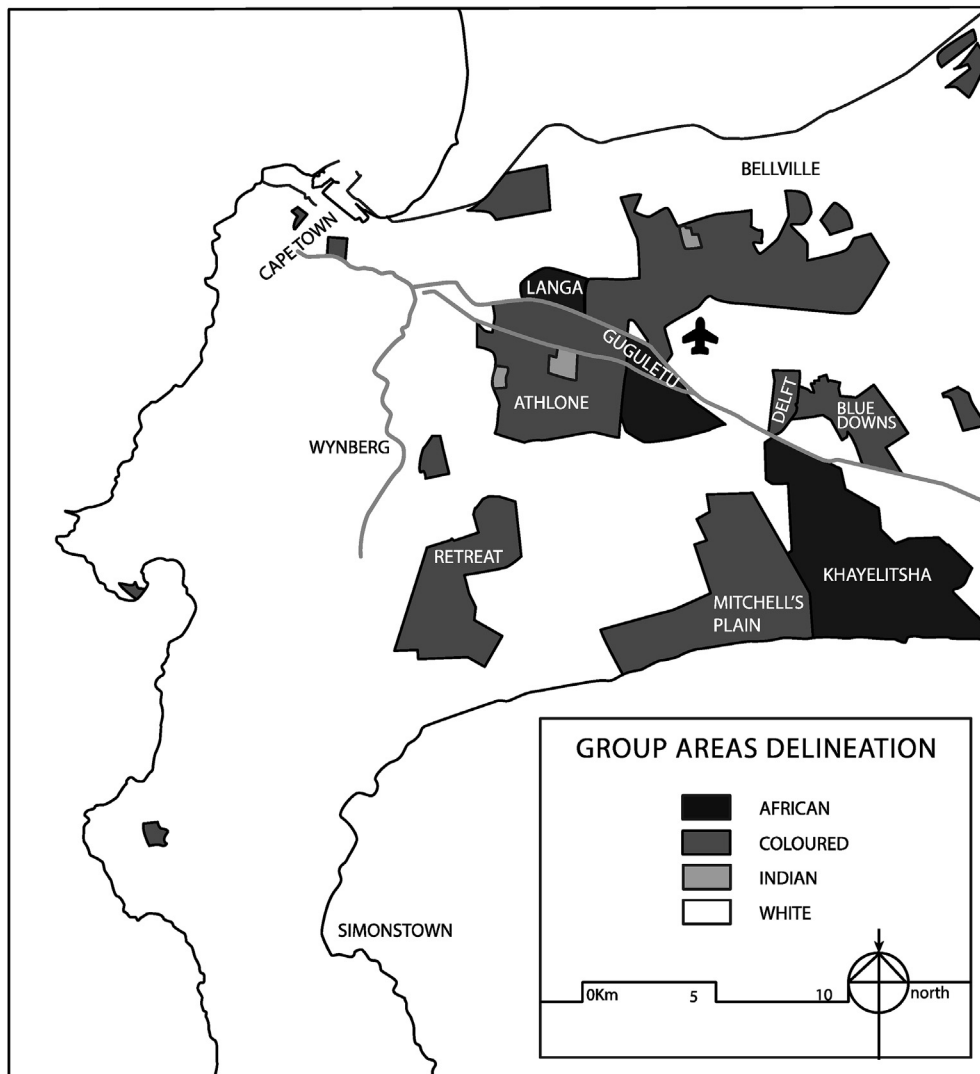


Fig. 1. Map of Group Areas Act delineations.

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