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Decolonising 'man', resituating pandemic: an intervention in the pathogenesis of colonial capitalism

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ABSTRACT

This paper brings together fifth-wave public health theory and a decolonised approach to the human informed by the Caribbean thinker, Sylvia Wynter, and the primary exponent of African Humanism, Es'kia Mpahlele. Sub-Saharan indigenous ways of thinking the human as co-constitutive in a subject we might call human-animal-'environment', in conjunction with the subcontinent's experiences of colonial damage in disease 'prevention' and 'treatment', demonstrate the lack of genuine engagement with Indigenous wisdom in Western medical practice.

The paper offers a decolonial reading of pandemic history, focused primarily on the human immunodefiency virus (HIV), the severe acute respiratory syndrome of 2003 caused by the SARS Covid 1 virus (SARS-CoV1) and COVID-19, caused by the SARS COVID 2 virus (SARS-CoV2) to demonstrate the importance of the co-constitutive subject in understanding the genesis of these pandemics as driven by colonial-capitalism. I emphasise that prevention will indeed take the kinds of massive changes proposed by fifth-wave public health theory. However, I differ from the proponents of that theory in an insistence that the new kind of thinking of the human Hanlon *et al* call for, has already been conceived: just not within the confines of the normative human of Western culture.

I illustrate that Western Global Health approaches remain constitutionally 'deaf' to approaches that, although the West may not understand this to be the case, arise from fundamentally different—and extra-anthropocentric—notions of the human. In this context, Man as Wynter names Him is a subject ripe for decolonisation, rather than a premier site of capitalist development, including that of healthcare provision.

Recognising that most of us are not individually able to change the structural violence of the colonial capitalist system in which Global Health practices are embedded, I conclude with implications drawn from my argument for quotidian practices that enable healthcare providers see their actions within a harm reduction paradigm, in the context of communities experiencing intergenerational impoverishment consequent on colonial violence.

INTRODUCTION

There have been numerous calls recently to decolonise health. Demands to move Global Health away from its origins in Western science intervening in tropical diseases to save native populations, abound Richardson, McGinnis, and Frankfurter 2019; Guinto (2019); Büyüm *et al*. (2020); Lokugamage, Ahillan, and Pathberiya (2020); Eichbaum *et al*. (2021); Richardson (2020); Richardson (2020). If we get it right, Abimbola and Pai (2020) propose, Global Health as a field should become obsolete (Will global health survive its decolonisation? 2020). The central argument of this paper is that we cannot move towards Abimbola and Pai's vision for decolonised Global Health without reframing disease in relation to its emergence within colonial-capitalist environments and their history. Colonial capitalism

> rests on the fundamental premise that capitalism has historically emerged within the juridico-political framework of the 'colonial empire' rather than the 'nation-state.' It grasps capitalist relations as having developed in and through colonial networks of commodities, peoples, ideas, and practices, which formed [and form] a planetary web of value chains connecting multiple and heterogeneous sites of production across oceanic distances. (Ince 2018)

Reframing tropical disease history using the decolonial recognition of colonial-capitalism as its context, results in a radical reframing of the human itself. This paradigm shift enables us to recognise colonial Man as pandemic-maker, and His decolonial alternative as health-making.

Fifth-wave public health theory (Hanlon *et al*. 2011) illustrates what is wrong with the colonial-capitalist present. It concludes with a call for a rethinking of the human; but this call can only be meaningfully answered by decolonial, non-Western ways of understanding the human, that exceed the scope of Fifth-Wave Public theory. I offer decolonial histories of the human immunodefiency virus (HIV), the severe acute respiratory syndrome of 2003 caused by the SARS Covid 1 virus (SARS-CoV1) and COVID-19, caused by the SARS -Covid 2 virus (SARS-CoV2) to illustrate the way in which 'the barring of nonwhite subjects from the category of the human' drives illness in the form of pandemic (Weheliye 2014, 3) (the severe acute respiratory syndromes are caused by a coronavirus—the CoV of the abbreviations—and appeared in 2003 and 2019 respectively, hence 1 and 2). My subsequent reframing of the human relies on the critical eye of a foremost Black feminist writer, theorist and legislator from the Caribbean, Sylvia Wynter; and an African Humanist (re)invention of the human as a co-constitutive being between/with non-human animals and their environment, a (re)imagining framed by Mpahelele's rendering of African humanism. This trajectory reverses colonial flows of knowledge in Global Health: sub-Saharan Africa is displaced as the site of disease ready for Western intervention becoming instead the site of health-making epistemology.

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The '*re*' in -invention and -imagining of the previous paragraph above emphasise that the target of decolonisation is the Western human, in His propensity for appropriation of land from native peoples; and the ease with which He commodifies not only land and non-human animals, but humans themselves, in the form of slavery and its afterlives. African humanism points us away from Man as master of all he surveys, to the human as co-constitutive with non-human animals and their environment. This paradigmatic shift—this decolonisation of the human its/ourself—enables us, I conclude, to see zoonoses as actually reverse zoonoses; that is, not as diseases that transmit from non-human to human animals, but as ones that are actually the reverse, transmitted from colonial humans' (actions and non-actions) to humans, non-human animals and the environment alike (sometimes called zooanthroponises). Further, if we understand colonial Man as the pathogenesis of modern pandemic disease, what does an intervention into what Sylvia Wynter calls 'the coloniality of being' (Wynter 2003) look like, at the level of the clinical encounter in Global Health? Connecting the overarching arguments about decolonising Global Health, to the practice of Global Health on the ground where larger policy shifts to decolonisation have not yet developed traction, is key to sustaining communities of healers and patients on that ground *now*.

FIFTH-WAVE PUBLIC HEALTH THEORY, THE COLONIALITY OF MAN AND AFRICAN HUMANISM

Hanlon *et al* first presented the concept of a 'fifth wave' in public health in 2011 (Hanlon *et al*. 2011). They give a history of public health since the industrial revolution. The first wave is associated with great public works and other developments arising from social responses to the Industrial Revolution, such as the provision of clean water. The second wave consists in the framing of medicine as a science. The third wave involved redesigning social institutions on a large scale, resulting in the welfare state. The fourth wave manifests in efforts to combat disease risk factors and the emergence of systems thinking. Although the waves continue activity in each successive wave, none reaps the rewards in improvements each wave achieved when it was first introduced. Hanlon *et al* concludes with a discussion of 'the (current) complex challenges of obesity, inequality and loss of well-being, together with the broader problems of exponential growth in population, money creation and energy usage. As exponential growth is unsustainable on a finite planet': thus, they infer, 'inevitable change looms' (Hanlon *et al*. 2011, 30). While others have approached the 'what to do' list after Hanlon *et al*'s call in terms of public health policy (Hemingway 2012) (Hemingway 2011) (Coggon 2020), this paper enters the debate by responding to their call in the forms of a decolonial approach in the wake of colonial capitalism.

The challenges fifth-wave public health theory seeks to address are best understood, I propose, as symptoms of the unsustainable ways of living promoted by late capitalist political, material and sociocultural practices of being in the world. These ways of being, and the (failed) promises attached to them, form a 'fifth wave' of public health challenges. By failed promises, I mean not only the putative promise that all will live at the level of the UK eventually; but also, the idea that this dream can be fulfilled within the majority of people's current lifetimes. Hanlon *et al* are careful to point out the role that the relative wealth of the UK plays in driving global inequality:

> Historically, public health advocates have suggested that inequalities will be combated by levelling up the circumstances of the poor to those of the rich…Today, if everyone consumed as much as the average UK citizen, we would need more than three Earth-like planets to support them… Despite all that they accomplish, current public health interventions are not solving the problem. Even if they were to succeed in their own terms, they are ecologically unsustainable. (33)

Public health interventions, then, have diminishing returns when the ways of being in the world to which late capitalism habituates humans, are themselves the ailment, not the secondary 'infections' they produce. Overwhelming poverty, substance (ab)use; malnutrition; overnutrition/obesity, and other stress-related illnesses have their drivers in working conditions and gaps between rich and poor. Hanlon *et al* conclude by calling for 'a new image of what it means to be human' (34).

The modern, Western human depends on a post-Cartesian split in which Man is divided into His mind and body, with the mind (supposedly) sovereign over the body. This has a corollary in Man, in mind over matter: Man, the subject, conforms to the normative human, who is (always, already) in control of everything else, which is relegated to object status: black; female; dispossessed; disabled; and non-human animals and the environment. It is precisely the post Cartesian moment that drives developments in fifth-wave public health theory: the rendering of medicine as a science and the development of experts, named as the second wave, occurred because humans started to see themselves as subjects able to observe phenomena objectively (Have 1987). The problem is (and was) not that they are able to do this, but that they are (and were) colonially inclined to discount other kinds of subjects as objects, who are therefore not included in the realm of the human.

Sylvia Wynter explains what this looks like from the perspective of those not included in the ambit of Man. 'Our struggle as black women has to do with the with … the displacement of the genre of the human of 'Man'' (288). Wynter proposes that, 'because of (the) overrepresentation by the genre of Man, which is defined in the first part of the title [of Wynter's article] as the Coloniality of Being/ Power/Truth/Freedom, any attempt to unsettle the coloniality of power will call for the unsettling of this overrepresentation' (260). Wynter states that truth, power and freedom belong to this 'Man'. Her use of the word genre points to the *framing* of man in the West. Western Man (who fits the Genre) is *not* all men: Western Man represents Himself as if he were the only kind of human there is; and simultaneously sees Himself as the epitome of the human, hence His 'overrepresentation' of Himself. To say we need a *new* concept of the human, then, is to deny concepts of the human outside of Western Man both as actuality—not everyone believes in the Genre of Man or behaves as if it is the only way of being; and as resource—Western Man may think he can reinvent Himself on His own terms, but these are likely to fail.

> The Genre of the Western Man is anthropocentric:
> In philosophy, anthropocentrism can refer to the point of view that humans are the only, or primary, holders of moral standing. Anthropocentric value systems thus see nature in terms of its value to humans… [E]ven arguments that advocate for the preservation of nature on the grounds that pure nature enhances the human spirit must also be seen as anthropocentric. (Padwe 2013)

The Genre of Man assumes anthropocentrism not only as a right, but also as the right way to be. No burden of explanation is placed on Man to explain his value in relation to his others, those relegated to object-status, in this system. Even when Man attempts to regard the other with respect, the notion of the other as object intrudes. For example, writing about the relations between empathy and violence prevention, Marc Gopin claims that 'the concept of nonviolence is complex, but at the root of the matter lies empathy with the potential *object* of violence, and a consequent revulsion from violence combined with a determination not to participate in it' (Gopin 2008, 1982; emphasis added). The emphasis here is on

the restraint of the subject, not on the value of that which is assumed to be an object—the 'it'. Furthermore, how can one have empathy for a being one regards as a thing?

With its foundational moves of acquisition of land through appropriation and slavery, capital-colonialism renders humans objects for exploitation. Extractive industries' exploitation of land, non-human and human animals are part and parcel of the same strategy of objectification. Insofar as national and international organisations motivate for such exploitation, they too can be described as extractive industries. Black Lives Matter strikes a chord (or discord) precisely because, thinking inside the genre of Man, Black Lives are perceived *as matter*: and those who have lived as black/brown matter, and those of us who bear conscientious witness to that non-mattering, know, and explicitly acknowledge non-mattering in the movement. The very flesh Global Health now seeks to heal, incurred its primary objectification and resultant vulnerability through thingification/commodification in colonial-capitalist practices.

Before turning back to the question of what the human may be beyond the Genre of Man, it is necessary to reflect on the inadequacy of the lens the Genre of Man uses to conceive of pandemic disease in all the latter's ecological complexity. I am not suggesting that without colonialism, there would be no disease. I am asserting that to consider the social determinants of health (SDOH) outside of the complex histories of colonial capitalism is absurd, much like trying to ascertain the shape of a planet through two dimensions. Sub-Saharan Africa can be seen as a locus of knowledge pertinent to decolonising major health challenges. It exemplifies the ongoing effects of capital colonialism in the present: it is the last part of the continent to be declared independent from colonial rule and its wealth consists in extractive economies. Further, infectious diseases, such as HIV and SARS-CoV2, are merely recent arrivals in a palimpsestic accumulation of indigenous health experiences that include malaria, syphilis, tuberculosis, typhoid, Ebola and cholera, to name but a few.

Here I give a brief (very brief) rehearsal of the geneses of HIV, SARS-CoV and 2019-nCoV, concentrating on the case of HIV because we have a good historical sense of its trajectory. This history illustrates colonial capitalism as crucial to understanding the genesis of pandemic and thus key to understanding the context in which we attempt to combat pandemic. The facts, then, are not new: The framing of them to highlight the ecological damage the Genre of Man inflicts on both the environment itself and the complex relations between human, non-human and the environment. It illustrates the need for a conceptualisation in Global Health terms of 'a politics of liberation beyond the genocidal shackles of Man' (Weheliye 2014, 3).

PANDEMIC HISTORY: A DECOLONIAL VIEW

As Pybus, Tatem, and Lemey (2015) point out, 'despite the importance of geography for infectious disease epidemiology, the effects of global mobility on the genetic diversity and molecular evolution of pathogens are under-appreciated and only beginning to be understood' (1). HIV has its genesis in the Kinshasa region, between the dates of 1910 to 1930, when the virus jumped the species boundary from its simian origins, initially because of bush hunting. (The reservoir populations of HIV are the red-capped mangabey (*Cercocebus torquatus*) and greater spot-nosed monkey; the transmission species is chimpanzees, who prey on monkeys.) What drove its spread, however, was the rapid growth of Leopoldville, which was under the direct, personal ownership of Leopold II of Belgium at the time (not the state of Belgium—that came later) and named after him. Indentured labourers were being captured to produce rubber; railways were built; sexually transmitted infections were high (at one point, Leopoldville had a male to female population of 2:1) and public health campaigns inoculating natives against diseases such as sleeping sickness involved the reuse of needles. The inoculations had to do with keeping a labour force, not concerns over the population health of native families and their communities. Indeed, the violence of the Belgian king against the beings in 'his' colony has been scrupulously documented: humans, non-human animals and the environment alike had one value: as a site of extraction (see, for example, Hochschild 1998). The setting was the perfect storm for a virus migrating from its reservoir population in the south of the Congo to Kinshasa and subsequently Brazzaville up the river.

In 2003 I was about to start work with colleagues in South Africa on an HIV/AIDS and GBV project. Our 'kickoff' meeting was held in the Toronto area. Much to the surprise of some of us, the South African contingent's supervisor was reluctant to let them attend, because Toronto was the locus of a spiralling pandemic at the time. (The surprise shows just how biased the global North-West is about perceiving disease as generated in the Global South, rather than 'at home'.) SARS-CoV1 first appeared in China's Guangdong province in November 2002. On 12 March 2003, the World Health Organization (WHO) issued a global alert, warning of atypical pneumonia spreading among hospital staff. Three days later, the WHO named the syndrome and put out an emergency travel advisory: the disease was spreading throughout the world by people using air transport. The areas affected included, at different moments, Hong Kong, Toronto, several areas of mainland China and Taiwan. Horseshoe bats are suspected to be the reservoir species of SARS-CoV, although masked civets are identified as the transmission species to humans, possibly in wet markets. Since 2003 there have been four small outbreaks of SARS-CoV1. However, the WHO warns that 'these events demonstrate that the resurgence of SARS [that is, SARS-CoV1] leading to an outbreak remains a distinct possibility' (World Health Organization 2003).

In January 2020, a novel coronavirus, SARS-CoV-2, was identified as the cause of an outbreak of viral pneumonia in Wuhan, China. The disease, first refered to as COVID-19 and now termed SARS-CoV2, subsequently spread globally. In the first 3 months it emerged, nearly 1 million people were infected and 50 000 died. It is relatively clear that bats are (once again) the reservoir species for SARS-CoV-2, but we do not yet know what the transmission species to humans is: It could be bats themselves or, as is more likely, an intermediate species or sets of intermediate species. Bats have long been known as an an important reservoir for many zoonotic viruses including rabies virus, Hendra virus, Nipha virus, Ebola virus and St. Louis encephalitis virus; and the coronaviruses that cause both SARS of 2003 and COVID 19 as well as Middle East Respiratory Syndrome (MERS). The key to both zoonotic (transmission to human) and anthroponotic (transmission to non-human animals from humans) prevention is to determine how reservoir populations, transmission species and the infected interact to prevent the spread of infection. For example, it was originally thought that pangolins, the most traded non-human animals globally, may have been the transmitters of COVID-19 to humans; however, the virus in the pangolins reveals that their disease was transmitted to them by humans, probably while hunting, selling or butchering the pangolins. Thus, conclude the scientists,

> our study suggests that pangolins are natural hosts of Beta coronaviruses. Large surveillance of coronaviruses in pangolins could improve our understanding of the spectrum of coronaviruses in pangolins. In addition to conservation of wildlife, minimizing the exposures of humans to wildlife will be important to reduce the spillover risks of coronaviruses from wild animals to humans. (Liu, Jiang, and Wan 2020)

A similar train of thought on required research comes from those working on the pathway of SARS between bats, civets and humans:

> The genetic diversity of coronaviruses found in bats highlighted our poor understanding of viruses in wild animals. …There is an increased possibility of virus variants crossing the species barrier and causing outbreaks in humans as people come into closer contact with wild animals. … It is likely that in the emerging path of SARS-CoV, there are still other species missing between horseshoe bats and masked palm civets. One way of revealing possible links and suspects is to look at the ecological circles of both bats and masked palm civets. Alternatively, constant survey of wild animal species for SARS-CoV- like viruses should provide further information on animal reservoirs. (Shi and Hu 2008, 84)

All the evidence suggests that the capture and consumption of so-called 'exotic' animals in conjunction with ever-increasing 'development' is triggering zoonoses and reverse zoonoses, that is, infectious diseases that spread from human to non-human animals.

It is unlikely that prevention of such pandemics will happen without research focused on a co-constituted subject that exceeds the genre of Man altogether: the non-anthropocentric and decolonial human-non-human animal-'environment' nexus. Its non-anthropocentricity is a benefit: The well-being of non-human animals and their supportive ecologies is a goal that affects humans but putting humans at the centre has resulted in a distortion of research priorities. For example, ignorance of, say, sooty mangabey (the source of HIV type 1) or common chimpanzee (HIV type 2) or masked palm civet (SARS caused by CoV1) or pangolin virus ecology results in zoonoses that drive interspecies pandemics. Further, shooting the messenger, such as the providers of bushmeat to families or of exotic meat to wealthy enclaves of consumers, won't prevent the problem, unless other modes of subsistence and wealth generation are found for hunters and traders in a variety of economic environments, from subsistence through to exotic 'pet' and meat markets. Blaming Chinese wet markets in a xenophobic rush, just as migrants were/are blamed for HIV in South Africa, constitutes versions of shooting the messenger: in each case xenophobia locates a false 'source' in an identity, rather than a set of relations.

Systemic conditions of capitalism bring human and non-human animals into dangerous contact zones within supposedly 'development' driven environments that shun conservation of wild-life habitat. Less recognised is the fact that these conditions simultaneously shun *human* habitat needs: 'Development' under the sign of the dollar does not improve overall human well-being. Instead, it deepens the divisions between wealthy and poor in extractive industries that create crises of capitalism and crises of pandemic. Those nations least equipped to deal with COVID-19 are those who are dealing with multiple health challenges. Allowing the disease to spread creates exponential long-term economic difficulties, revealing the supposed rationality of 'getting the economy going' by ignoring the pandemic's current and future potential for harm as a doomed strategy.

From this perspective, 'crises of capitalism' are not merely the sequelae of capitalist economics, but the very embodiment of an ill planet, manifest in increasing waves of pandemic morbidity in relations between human animals, non-human animals and what we call the 'Environment'. (I use scare quotes around 'Environment' when I mean it to refer to the Man-centred concept of Environment with a big E, but not when I intend it to be part of the co-constituted subject, human/non-human animal/environment.) Viewed through the lens of fifth-wave public health theory, colonial capitalism itself can be seen to be the extended pandemic that has enabled and will continue to enable pandemic 'zoonoses'.

Zoonoses is in scare quotes above because a decolonial, non-anthropocentric approach enables us to see these zoonoses as actually reverse zoonoses or zooanthroponoses (passing from human to non-human animals) at the systemic level (Messenger, Barnes, and Gray 2014). It is the role of Man in global 'development' that has brought these diseases to bear through the concentration of human and non-human contact in zones under ecological stress. The paradigmatic shift from zoonoses to reverse zoonosis important. It means we are able to see the origins of Ebola or HIV or COVID-19 in sites under hypercapitalist stress (Vujnovic 2017), such that Man, in His drive for ever-increasing comfort and wealth, is the driver of these diseases in a way that the sooty mangabey, or the common chimpanzee, or bats or civets cannot be. Man dictates a set of values entangled in capitalist-colonialist object-making that creates the conditions for supposedly zoonotic pathogens.

If we recognise this, we can see that Man has occluded himself from the picture to His own detriment. As He looks through the latest equipment to isolate pathogens, Man appears unable to return the gaze on Himself as intimately related to the pathogen at hand. Successful vaccines for COVID-19, then, are merely (temporary) solutions to the novel coronavirus variants that cause it; more pathogens will follow, precisely because the ecological stress on human and non-human environments is growing exponentially as the physical contact zones between species are shrinking under global hypercapitalism (Messenger, Barnes, and Gray 2014). The abbreviated history I have given of SARS, HIV and COVID-19 illustrates this point: pandemic waves are likely to both reiterate the weaknesses in the system and rise in both incidence and prevalence across the globe.

Curiously, as Man occludes himself, His sphere of reference—the environment—also disappears. The 'Environment' He can see is that which arises from the post-Enlightenment split of the human and that which is other than the human; or the split between subject and object. Ecological health approaches see this as man's estrangement from the natural world and go so far as to claim that 'we call it 'rape' when we objectify a person; but when we objectify nature, we call it science' (Coope 2021). In order to stitch together the subject-object division, we need to define a co-constituted subjectivity that we might call human/non-human animal/'inanimate' matter. But 'we' (those of us within the Genre of Man) do not need to, and cannot, as I argued above, do this 'ourselves'. To think the human differently, a genuine engagement with different epistemologies from those of the West is needed. What knowledges *already* understand the world beyond the subject/object (or colonial/native or scientist/pathogen or experiential/scientific) binary?

THE BEING OF AFRICAN HUMANISM

When asked about the meaning of African Humanism, South African writer Es'kia Mphahlele talks persuasively about the deep-seated belief of sub-Saharan Africans in the wisdom and company of the ancestors (Mphahlele 1997). He also remarks on the tradition of the burial of the afterbirth or placenta by the mother or a close relative in the family compound, as a symbol of the circularity of the life cycle, where the placenta represents a unique conjunction of the unborn, the born and a tribute to the ancestors in the very ritual of burial (Mphahlele 1997). Mphahlele addresses embodiment through the buried afterbirth, a metonymical part of the co-constituted effluent subject, unborn-living-ancestors. One can perhaps see the 'addition' of the ancestors to the notion of enduring Western humanism as that which makes (Mphahlele's) Humanism African

(add 'ancestors' and stir); but what Mphahlele says next makes it clear that this move would be impossible:

> I should also say that in African Humanism there is no dichotomy between the material world and the spiritual world. There is a continuity reinforced by interrelationships and interconnectedness. That is animal life, plant life and inanimate objects have a life of their own which is part of us. Which is why, for instance, a traditional healer will use organic matter to heal the body, it will be something plucked from nature, because there is a unity. Part of the continuity is also dramatized by the way in which women will take their afterbirth and bury it in the vicinity because it symbolizes reincarnation, the cyclical pattern of existence. (184)

The emphasis Mphahlele puts on the burial of the afterbirth is probed by Samin in the question, not flippant, of what happens to the tradition of burying the placenta in the compound when one is no longer in the rural areas, but in the city. Mphahlele responds that he sees the interruption of the tradition of midwifery and burial of the afterbirth in the modernisation that leads to women giving birth in clinics and hospitals negatively. After discussing the demise of this tradition, he comments: 'African humanism has been battered a lot and we need to regain our balance' (184). 'African humanism', here, is directly opposed to the separation of community entailed in birth in the clinic/hospital. Moreover, Mpahlele defines an *Ubuntu*-sourced, compound subject missing from the discourse of modern medicine: that of a co-constituted subjectivity which we might call human/non-human animal/'inanimate' matter.

Ubuntu (isiZulu) has many definitions. Here I am drawing on its mutuality and including non-human animals and environment, both built and naturally occurring, following Mphahlele's lead. In *Ubuntu*'s claim—'I am because we are' or 'We are mutually constitutive'—I do not read the I or the We as being confined to the Genre of the Human. In this I differ from the Christian-inflected *Ubuntu* described by Archbishop Desmond Tutu in venues such as his Peace Foundation (Desmond Tutu Peace Foundation 2015). Human/non-human animal/environment ethics of mutual care are required, to conserve that compound subject. Until these three partial subjects are understood as co-constitutive along lines of intimacy that materialise as intermingled care and enjoyment, colonial capitalism and its cult of Anthropocentric fetishism cannot but result in ever increasing waves of 'zoonotic', or rather, reverse zoonotic, disease.

The compound subject of *Ubuntu* is a crucial resource for addressing pandemic as problematic that the Genre of the Human is not capable of solving. Take, for example, the ways in which the term, the social determinants of health (SDOH), calculated to address structural violence, is pre-empted by the inability of its concepts to comprehend radical mutuality. The term currently used by the National Institutes of Health to describe contexts of health debility is the SDOH, sometimes expanded to the social and economic determinants of health (SEDH): 'The term social determinants of health refers to the complex, integrated and overlapping social structures and economic systems that include social and physical environments and health services. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world' (Centers for Disease Control and Prevention 2014). The US Centres for Disease Control and the National Institutes of Health (NIH) base their definition on the United Nations report finalised in 2008 (Commission on Social Determinants of Health 2008). Interestingly, the places where the term is most employed, is in relation to explicitly recognised 'vulnerable populations'; so, for example, the websites in which it plays a greater role than elsewhere in the NIH sites include the National Centre for HIV/AIDS, Viral Hepatitis, Sexually-transmitted Diseases, and Tuberculosis Prevention (Centers for Disease Control and Prevention 2021) and the National Institute of Minority Health and Health Disparities.

The term SDOH gives the unfortunate impression that the structural violence of inequity can best be addressed through attention to *minority* health concerns, which is analogous to focusing on victim survivors to prevent assault. It is not minorities or the dispossessed, for the most part, who deprive themselves of wellness. Absent in the NIH definition of SDOH is the fact of medicine in the USA as a key site of corporate profit. Attention is paid to victims of structural violence, but not its beneficiaries in financial terms; nor to intergenerational histories that produce such negative outcomes in the underserved. In this respect SDOH, while explicitly intended to talk about the SEDH, rarely mentions colonialism or slavery as the antecedents of the current global system, rendering SDOH not as much an explanation of why radical inequities came to be, as a strategy of containment: a framework that recognises victims, but not the beneficiaries of colonial capitalism as perpetrators of structural violence.

The production of healthcare as a profit centre merely continues the logic of dispossession and slavery in its use of the human body as an extractive industry. The healthy human is no longer they who can access to healthcare, but they who can purchase a healthy Bubble in which to live, that includes areas to exercise, good food, less pollution than other areas, freedom from discrimination and the same resources for one's immediate family. Even then, what mitigates against wellness is the ability to purchase convenience: '… Since the mid-1970s increased economic growth in the USA, Europe and Australasia has not been accompanied by improvements in well-being, which may now be declining' (33). Not even the privileged are necessarily well.

THE TROPICAL EXOTIC IN GLOBAL HEALTH: 'RESCUE' MEDICINE AS COMMODITY AND PATIENT 'CONSUMERS'

In Global Health, 'developing' communities are often constructed as the receivers of the 'gift' of health technologies, an example of the continuation of colonial practice into the present. 'Cultural competency' makes short work of attempts to pose indigenous health knowledges as sources, rather than barriers, to knowledge that frames infectious disease as an extra-anthropocentric matter. Moreover, Global Health's attractions for Western-trained professionals create structural violence, in that sustainable development and skills transfer on ground in sub-Saharan Africa, were they to exist substantially, would diminish opportunities for the current demand for a (reversed) health tourism, in which doctors from developed countries seek experiences in the Global South, where the needs of the underserved in their countries of origin 'go without'. Such opportunities exemplify a colonial capitalist approach to sub-Saharan African populations within the 'Global Health' economy: Indigenous patients become an extractive industry. Further, this approach overlooks the capacities that have indeed been developed in the countries that are the supposed beneficiaries: South Africa has a superb cadre of domestically trained healthcare professionals who have been on the front lines of research and care on challenges ranging from excessively drug-resistant tuberculosis (XDR TB) and HIV to endemic hypertension in rural communities.

Although it was over two decades ago that Warwick Anderson wrote 'Where is the History of Postcolonial Medicine?' we are still 'writing a minor literature' (Anderson 1998, 523). This has deeply problematic actual effects as Western medicine is assumed to be both normalised and superior to indigenous traditions and cultures of healing and wellness on all counts, as Bleakley, Brice, and Bligh (2008) point out:

> Western medicine and medical techniques are being exported to all corners of the world at an increasing rate. In a parallel wave of globalisation, Western medical education is also making inroads into medical schools, hospitals and clinics across the world. Despite this rapidly expanding field of activity, there is no body of literature discussing the relationship between post-colonial theory and medical education. We need to develop greater understanding of the relations between post- colonial studies and medical education if we are to prevent a new wave of imperialism through the unreflecting dissemination of conceptual frameworks and practices which [stet] assume that 'metropolitan West is best'. (266)

'Cultural competence', for example, constitutes an instrumentalist set of tools for more efficiently conveying the authority and superiority of Western medicine in contexts in which such superiority could be questioned by indigenous and postcolonial communities.

The Centers for Disease Control and Prevention (CDC) takes its definition of cultural competency from the United States Department of Health and Human Services, Office of Minority Health, which assumes that the patient is defined above all as a 'consumer' of Western health services, despite the document's apparent concern with identifying the health provider's own beliefs as a potential barrier to positive outcomes in situations where the aforementioned 'consumer' is of a minority. The CDC draws from the Health and Human Services document, stating that 'Competence' in the term cultural competence implies that an individual or organisation has the capacity to function effectively 'within the context of the cultural beliefs, behaviours, and needs presented by *consumers* and their communities.' (Centers for Disease Control and Prevention 2014; emphasis added).

Following Warwick Anderson, cultural competence pedagogies do not ask, 'what is colonial about Western medicine in any setting [?]'. They assume that the Western-trained healer is able to develop competence in the culture of the other; or at least, is able to develop sufficient 'skill' to impose Western medicine authoritatively in the cultural setting of the other/patient. The practice of medicine in conjunction with the allures of the postcolonial exotic create a fatal medical neo-imperialism (Jolly 2016). My first example is taken from personal experience. I spent 3 years of my childhood in Lesotho, an independent nation enclosed by South Africa, in a mission hospital where my father was the only doctor for 40 000 square miles, and we lived in the geographical centre of the country along the infamously treacherous 'Mountain Road'. We would get well-meaning donations to the hospital that made us laugh and cry at the same time: an unbelievably expensive piece of a heart transplant machine, which we then had to find a buyer for to garner the income for the hospital's needs; and hundreds of disposable needles that had already been used. The postage expended to get them to us we could well have been deployed for real needs. Who, one wonders, thinks that disposable needles are reusable? (I should add that the piece of heart transplant equipment did offer us several hours of entertainment while we tried to think up other uses for it in the hospital setting!)

Lesotho depends on charity, migrant labour and garment work, as well as subsistence farming. The country is among the 'Low Human Development' countries (165 of 189 on the Human Development Index as classified by the UNDP), with 54.3 years of life expectancy at birth. (United Nations Development Programme 2020). According to 2020 estimates, the prevalence is about 21.1%, one of the highest in the world, with 280 000 living with HI, 7700 new HIV infections, 4700 deaths and 82% (232 984) of adults and children on HAART (UNAIDS 2021).

I once had a discussion with a colleague who was taking groups of students over to a Canadian-sponsored HIV clinic in Botswana; he figured he could keep the clinic going through rotations of medical students and locums from Canada indefinitely. He was mirroring the approach of Philip Berger, who worked at a Basotho clinic under the auspices of OH Africa, who set up the clinic in late 2004. (OH Africa is a not-for-profit associated with the Ontario Hospital Foundation). The clinic was due for a normal transfer from foreign to Basotho government for control, as was recognised by the Canadians themselves. However, as the takeover loomed, Berger and OH Africa warned of a 'life or death' crisis at the clinic, due to the withdrawal of the Canadian staff, a refusal of the Basotho national government to pay for 15 local workers, and fear that integration of the clinic into the hospital would lead to stigma-related avoidance and a diminishment in care standards.

The clinic at one point boasted of having attracted 50 Canadians to its locale, which raises the question of what programmes of skills transfer and indeed, clinic transfer to the central government, were in place. HAART administration only becomes a complicated business when rarer forms of resistance to regimes appear. However, this is used as a threat in an instantiation of Canadian superiority in the language of the letter written to the Basotho government by the OH Africa and Dr Berger:

> Now, after a dispute with the Lesotho government, the Canadian donors are warning of a nightmare scenario. Patients could die, they say, and the clinic could spark a public-health crisis by spreading drug-resistant HIV strains across the border to South Africa.
> Health professionals at the clinic are already beginning to leave, and key programs are disintegrating. 'This is a life-and-death urgent matter for the people of the region,' said Philip Berger, a Toronto doctor who specializes in AIDS treatment and has worked at the Lesotho clinic as recently as December. (York 2010)

This implies that new strains of resilience are not spreading within South Africa itself and often come from there, a patently empty claim: South Africa has a far more advanced system for detecting and dealing with such strains, and a far larger population in which to develop them.

The point is not new, but also apparently *not* persuasive: Skills transfer between local and global professionals should be part and parcel of the plan. By skills transfer, I mean a two-way communication, not one way from Global North to South—even though that seems impossible to achieve, due to current colonial stereotypes of the resources of global South medical care. I understand that there would be resistance on the part of clinic goers to the change in care, which may be less personalised, require further travel (a huge problem in the service of the highlands in Lesotho in particular), seem less 'high tech' and therefore be perceived to be less effective. Working within a hospital administration poses barriers not encountered in individual, specialised clinics, no question, as I experienced in my own attempts to integrate NGO rape crisis clinics into hospitals in rural KwaZulu-Natal, South Africa. But what does it mean to develop clinics in Lesotho and Botswana that depend on rotating medical staff trained in Canada on 'locums' and fixed term work at the clinics, or, as the Minister of Health of Lesotho, Mphu Ramatlapeng put it: 'They experienced a very high turnover of staff and they failed to meet certain targets', she said in an email to *The Globe*. 'They failed to integrate the clinic services with the services of the main hospital. They also failed to assist us with decentralised services to the clinics' (York 2010).

Westerners founding clinics in the global South are often not attentive to the repetition of the hubris of postcolonialism and the cost of that hubris to populations. At issue is the lack of the sustainability of foreign interventions, just as it was when the Belgians failed to train successors when they pulled out of the Congo on 30 June 1960. The ensuing development of the postcolonial state, in part by ex-patriot

Haitians, is the factor which Piot and others, such as Oliver Pybus, infectious disease specialist and evolutionary biologist at the University of Oxford, attribute the introduction of HIV to Haiti. Returning ex-patriots brought the genetic forerunner of the current epidemic back to Haiti with them from the DRC (Faria *et al*. 2014). Also at stake are postnatal care units and other physical areas of the hospital that offer highly unstigmatised and long-standing services, including TB services, which have a long history in Lesotho due to the migrant mineworkers. HIV drug resistance (HIVDR) is an increasing threat to treatment globally: the development of laboratory capacities for testing goes in hand with country ownership and governance mechanisms to ensure sustainable responses to HIVDR.

The central barrier the coloniality of Western medicine presents, is the question of trust (Richardson, McGinnis, and Frankfurter 2019). The sad history of the infamous Tuskegee syphilis scandal, taught repeatedly in ethics training modules for researchers, repeats itself on a global scale (Gamble 1997). In a contemporary iteration, there has been much outcry against the WHO's determination that the use of Depo-Provera reflects new 'evidence' that women at high risk of HIV can use any form of reversible contraception, including progestogen-only injectables, implants and intrauterine devices, without an increased risk of HIV infection in sub-Saharan Africa. Dr Jessica Rucell of the University of Cape Town, among others, has said that the ECHO Trial did *not* prove that Depo Provera was safe, as the WHO claims: 'Since the early Provera increases one's risk of contracting HIV. Unfortunately, the ECHO trial could not conclusively measure this risk. This is because the trial only measured if using Depo would cause more than a 50% increased risk'. The question remains: Why does the WHO 'seem… to agree that a 2% or 30% increased risk of contracting HIV is not 'clinically relevant' for African women?' (Rucell cited in Green and Pilane 2019)

Before the availability of ARVs in South Africa, *Sangoma* (traditional healer) Benghu reminded me once, the folks at King Edward VIII Hospital in Durban used to tell patients with HIV from the Valley of a Thousand Hills to 'go home to die'. It was the traditional healers that supported them in their quest as to *how to live with HIV/AIDS*. Conceiving of the ill postcolonial citizen as a victim only Western medicine can save, is rife with fantasies of humanitarianism, technological superiority and the zeal of Western medicine to practise under the sign of the exotic tropic. What might a way out of this conundrum be?

IMPLICATIONS OF THE ARGUMENT FOR QUOTIDIAN DECOLONIAL PRAXIS

In years' worth of interviewing young men about their attitudes towards HIV and gender-based violence, despair emerged as a key driver of HIV illness in the region (Mngoma et al. 2021). Young men were asking, what is the point of taking antiretroviral therapy when there is no life ahead of them in terms of education, jobs and other forms of opportunity? In this context it made sense that some youth would choose to sell their ARVs to acquire other materials, including illegal drugs. These young men pose the unstated question: what are you (the doctor and the technologies you use) keeping me alive *for*? Risk-taking behaviour becomes endemic when opportunities for the future are highly constrained: youth are especially at risk (Sanci, Webb, and Hocking 2018).

The work of fifth-wave public health theory brings us to the 'to do' list. Hanlon *et al* have six recommendations for dealing with the fifth wave of public health, some of which are germane to this discussion. These are to move 'from dominion and independence (through specialist knowledge and expertise) to greater interdependence and cooperation'; to put humanity back in the picture, not as automaton to fix it, but as combining objective (medical science) and the subjective (lived experience); and to develop different kinds of growth than the economic. While I cannot suggest I have solutions at this massive scale, I conclude with a set of aspect-changing perspectives that are informed by the decolonial intervention on Man in the context of Global Health. I offer them as a modest proposal for quotidian decolonial praxis, rather than a set of solutions in and of themselves.

None of us is singly able to contest the structural violence of colonial capitalism to bring about radical change globally: a factor that contributes to depression and anxiety. It may be helpful, then, for those working in Global Health contexts, including impoverished settings in the North, to think of working not to cure per se, but as practising *harm reduction* within capitalist colonialism. Harm reduction, widely employed in substance use contexts, is defined as 'a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs' (National Harm Reduction Coalition 2020). Many of our global societies are addicted to capitalism (Courtwright 2019). It thus makes sense to treat ourselves and our patients as always already in situations of harm, in which the symptoms of our way of life need to be treated in the context of harm reduction, rather than cure. We need to respect ourselves for any inroads we make in harm reduction in the context of colonial capitalism, both in terms of viewing ourselves as healers, and having a collaborative respect following from that for patients. For example, we can treat patients like the young boys of the Centocow valley without assuming we can make life worth living for them just because we have helped patients physically to live. This means being *with* patients in the debility caused by colonial capitalism, rather than thinking of (us as) healers, as needing to shed (our) vulnerability to 'heal' patients. It may not be appropriate always to express this mutuality of vulnerability; some patients have a need for the healer to be composed as the patient has space to be uncomposed. But the aspect of mutual vulnerability undoes the colonial relations of doctor to patient. It is an element of self-care for both healers and patients: healers need not leave patients feeling as if they've failed because they cannot 'fix it all'; and patients can leave the clinical encounter not feeling as if they are *supposed* to feel cured in mind and body.

Recently empathy has attracted attention, particularly cross-cultural or *radical empathy* (Givens 2021), that is, empathy beyond a group one identifies with as one's own. It is important to note that a decolonial approach to empathy for healers cannot begin with assuming knowledge (Pedwell 2014), but rather as an attitude of wanting to care for and value a patient's experience, but understanding that one does not, in the first instance, know how to do this: Assuming one understands how a person from another culture views illness, let alone their own illness, creates radical breaks in the clinical encounter (Datta 2017). Assuming these ruptures don't exist, is a colonial approach to empathy.

I worked with women who lived with abusive fathers. Often leaving the household was impossible, due both to a severe lack of shelters and different loyalties. In one case an elder sister would not leave her father's household because she had promised her mother on her mother's deathbed that she would protect her younger sister from the abuse of the father. This young woman, who was acting as a buffer zone between her father and her younger sister by enduring the father's rape of her, had the traditional respect for the ancestors (those who die before us) and consequently explained that she would cease to live, if she deserted her sister, breaking her promise to her mother. Ultimately, but not immediately, shelter was found for both. (Shelters are spectacularly hard to find in the area she came from, as shelters are rare enough but shelters that take

mothers or sisters and their children/younger siblings are virtually non-existent.)

This brings me to my next point, which is that assumption of empathy without knowing the specific context of the patient, can cause the patient shame and stigmatisation. I define shame as coming on the patients when they (the patient) realise that the caregiver experiences the patient in a way much different that the patient experiences themselves (Jolly 2010, 82–116). Lice, for example, are part and parcel of living in some of the rural huts where the patients I worked with lived. A mother may bring in her baby for a check-up and the baby might be doing fine, but for the lice, and the mother sees herself as being a good mother, as well she should. Yet novice caregivers, as I once was, can make a mother feel inadequate for a condition of living totally beyond her control by remarking on the lice as something that can be 'cured'. (They can be got rid of, temporarily, but they will reappear in this context: the stress to baby and mother is not worth the outcome.) The self-consciousness that a caregivers' assumption of their own norms may unwittingly inflict on patients of an entirely different world from themselves, can be excruciatingly painful. Highly active antiviral regimens for HIV require food. But how one asks a patient about household economics can be so clumsy that a patient is brought to lie about the amount of food in the home to avoid shame and stigmatisation. The question is not simply informational for the patient, even if the caregiver regards it as such: it requires the patient, should food be scarce, to enter a kind of modern-day confessional. *In a decolonised clinical encounter, the patient would not experience the interaction as confession, as shame.*

Shame can lead directly to patients withdrawing or withholding themselves from the clinical encounter (Lazare 1987). Issues of stigma in the provision of healthcare often come up in contexts of obesity (Selak and Selak 2021), mental health (Robson and Lian 2017) and the homeless (Purkey and MacKenzie 2019). Yet there is a point yet to be made about unintentional stigma arising in Global health settings where income, racial and cultural differences proliferate. I was once teaching a Bioethics class of seniors when we got into a discussion about what it means to go for birth control in Philadelphia, from where two of the students came. The white student reported that her doctor has congratulated her on seeking out birth control so that she had future control over educational and professional options, while the black student reported she had been treated as a licentious woman and repeatedly warned about the danger of contracting sexually transmitted infections. No wonder black women don't seek out reproductive care in this context.

Finally, I propose that a sense of *mutual vulnerability* (Malterud, Fredriksen, and Gjerde 2009) in the context of colonial capitalism can prompt better exchanges of knowledge between professional healers of the North and South. I am not simply talking here about the techniques of Western medicine. I am talking about the ways in which healers in the underdeveloped medical systems of the global south have experiences that northern doctors don't have. A colleague of mine from the North was once asked to help with a Caesarian section in a rural African hospital. When she came out of the hospital she stumbled as we walked to the 4x4 used to navigate tricky roads in the wet season. She said she couldn't work multiple-gloved. This was the custom of the medical staff to prevent against needle stick injury, but she judged her own performance as relatively useless. It's like operating while being the Pillsbury Doughboy, she told me: I haven't ever done it before.

Another skill I return to, is that of Sangoma Makhosi Nokusho Benghu, who was able to teach the young man with HIV from the Valley of the Thousand Hills to live with the disease, when the doctor at King Edward VII in Durban told him to go home to die. She discussed with him techniques for living in the community, for preparing for his death—in this ontology, his preparation to be an ancestor—and met with him in ways that ensured confidentially, leaving him in control of his representation of his sickness to his community, while he rehearsed different modes of doing this with her. Sangoma Benghu is recognized for her integration of traditional and Western medical healing methods.

Western Health approaches remain constitutionally 'deaf' to what the co-constitutive subject, human/non-human/'environment' tells us: That the 'treatment' of patients to be made fit for what passes for life in instrumentalist terms, is profoundly insufficient. From this perspective, Man as Wynter names Him is a subject ripe for decolonisation, rather than a premier site of capitalist development. Decolonial approaches have the capacity to interrupt capital colonialism as a pathogenic cycle capable of producing zooanthroponoses in (the wake of) Man, who himself can be seen as the non-sustainable entity so avaricious for exploitation that he eats his own tail fantasising that it belongs to another (consumable) entity. However, as Hanlon *et al* point out, whether the necessary change will result in adaptation or crisis, is unforeseeable.

Instead of setting objectivity against subjectivity, they can both be aligned in a *syncretic process* (Stoner 1986): Western medicine may be able to deal with some elements of the fifth-wave public health challenge well; in some cases, profoundly different approaches are called for. Syncretism means that Western-trained medical healers do not have to put their skills aside; we do have to decide when and how and where to deploy them, with the awareness tha Indigenous peoples have a body of knowledge from which we can learn; and learn to respect; and learn to use to evaluate our own skills. What we can do, in a spirit of harm reduction, is *Lindanathi* (isiXhosa): 'Wait with us'. 'Waiting with', as Masande Ntshanga points out in his novel, *The Reactive*, is *not* doing nothing (Ntshanga 2016). It means recognising ourselves as a plural subject, whose mutual recognition of radically different skills, values and ontologies—a *process* that requires care-filled listening and patience—may yet lead us towards being as enjoyment, rather than fixing, solving and owning; and as healing.

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