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Controlling Epidemic Disease to Birth Control: An Understanding of 'Postcolonial Condition' of Western Medicine in Bangladesh

1. Prelude

In this paper, I engage with the idea of 'colonial relation of native body' to explore the ways contemporary intervention of Western medicine is associated with the rise of new forms of govenmentality and sites of domination in the context of Bangladesh. To do so, I attempt to delineate what 'postcoloniality' might mean for understanding the dominating nature of Western medicine in Bangladesh. In general, the term postcolonial '... has been taken to mean not just the period subsequent to political independence in the former colonial world but the most recent phase of that period' (Robotham 1997: 357). However, many advocates have raised questions about 'the postcolonial', which have been used very differently across disciplines and have proposed alternative formulations to that term (Dirlik 1994; Prakash 1992; Hall 1996). My aim is not to enter the debate but to take the more modest task of looking at the specificities of one area in health sector in Bangladesh. This allows me to see how colonial legacy is still prevalent in the contemporary world situation. In other words, how colonial legacy of Western medicine continues to operate quite freely in the present, what I would call 'postcolonial condition'. In the period of colonization, the apparatus of direct colonial rule devoted to control human body. The subject of 'Western medicine' focused upon 'ill-body'. But in the postcolonial context, 'Western medicine' does not control or treat only an 'ill body' rather its area has extended to any type of body; even which is not 'ill'.

My emphasis on the postcolonial condition is intended to draw attention to the domination of western medicine that shapes the lives of

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people in Bangladesh. Thus, I am interested in the discourses of Western medicine which position subjects and which configure their self in the name of population control, and not just with a body of theory that we call 'postcolonial theory'. I use the postcolonial condition because it enables me to describe and analyze the condition of human being, their health practices and their forms of health domain. In postcolonial condition, development discourse makes people subjects in its Foucauldian sense: subjected to domination and dependence. What is important in new postcolonial condition is to provide a narrative of development that based upon human progress.

Thus, population control is presented as a means of achieving that progress in quite a different way than it does colonial discourse. It does so not only by controlling the existing human body, but also by offering new contraception ideas in the Western narratives of development. Norplant is such a Western medical production, which is used as contraceptive to control over the population. This idea's has profound consequences for the project of development. Controlling population will enhance personal growth that will eventually serve the growth of the nation. Population control is anthropomorphized. In postcolonial condition, a life stage of human development is equated with nation development. In other words, nations are newly born; they need 'tolerable' populations to 'grow' that in turn will reduce their poverty. Norplant, as a technique of birth control, has been using for the population control.

There are four parts in the paper. The first part starts with a conceptual uses of the term of 'postcolonial condition' for raising questions about Western medicine to that term in an attempt to the contemporary world situation. The second part explores David Arnold's idea about colonizing process of body and considers the implications of new forms of body for the operation on human being. The third section addresses the ways in which Western medicine expands its new horizon of operation through introducing contraceptives such as Norplant in order to control human population. In this section, I take Norplant as a case to understand uses of contraceptives for population control. Finally, I draw a conclusion by arguing that the colonial domination of Western

medicine continues to operate quite freely in the present, although not with the same valences, but in new ways.

2. Epidemic Disease and the Establishment of Western Medicine in Colonial Period

In his book, *Colonizing the Body*, David Arnold (1993) talks about the colonizing process of body. He relates the treatment process of epidemic diseases in colonial period with the Western medicinal control on body. He shows this relation by narrating three different case studies: Smallpox, Cholera and Plague. Arnold explores the Indian responses to Western medicine. He emphasizes on political and cultural issues of the body in a colonized society as reflected and refracted in medical discourse and practice and as manifested in the varying perceptions of, and responses to, epidemic disease (Arnold 1993: 7). Arnold explores these responses with the history of 'Western medicine' in India.

Western medicine in India had passed different trajectories. Before 1800, it had made few inroads into India and was largely confined to European enclaves and ports (Arnold 1993: 11, Bala 1991, Sultana 2004). Even, Europeans sometimes turned for help to India's *Hakim* and *Vaidys* and their readiness to seek Indian assistance. The cause, for seeking this assistance, was a belief that local healers would be more familiar with the disease of that climate and with the locally occurring medicines. However, a hundred years later, a dramatic transformation had occurred in both the character and the relative position of Western and Indigenous medicine in India (ibid:11). At the end of the nineteenth century, Western medicine enjoys a formidable degree of authority over British India, within the councils of government and over the lives of its 300 million subjects (Arnold 1993: 12, Chakrabarty 1998, Sultana 2004). This establishment of authority over Indians was interrelated with a series of momentous changes that were taking place in Western medicine at the time. Some developments, such as vaccination against smallpox in the 1800s or the Contagious Diseases legislation of the 1860s, passed rapidly to India. Others, like the public health movement or the germ theory of disease, though slower to find a footing, were eventually able to establish themselves (Arnold 1993: 290, Chakrabarty 1998: 162, Sultana 2004).

One of the major issues of the consequence of germ theory was to control the disease or the epidemic condition of disease. British colonial understanding was controlling the germ to control the epidemic. Therefore, the intended interventions towards epidemic control were examining human body for germ identification, separating affected body from the healthy one, hospitalization of affected people, destroying affected property (Arnold 1987, 1993; Chakrabarty 1998; Sultana 2004). Conversely, Indian understandings of epidemic were rooted into its cultural beliefs of diseases, where diseases have been addressing with curse of supernatural power. Therefore, the notion of disease had differential meaning. At the same time, body investigation and hospitalization process of Western medicine were considered to the local people as humiliation (Arnold 1987, 1993; Chakrabarty 1998; Sultana 2004). In other words, local people believed that the new processes of bio-medicinal examination of human body were dishonorable for them. Local people started resisting these new examination processes. Epidemic, like plague, control scenario is a good example to understand the colonial interventions, and its local responses.

The early years of the Indian plague epidemic provides an important illustration of the complex interplay of coercion co-operation, resistance and hegemony, class and race in the colonial situation (Arnold 1987: 90). This illustration also reflects the different perception of South Asian conception of body from Western medicinal perception of body. In the early years, plague had tried to control with a particular policy where 'for the treatment being body was separated from its social existence'. Investigating body for germs, separating ill body from the healthy one, hospitalization of ill body were the common British colonial interventions in plague control. However, there were local reaction and resistance against the plague control interventions as well. Rumors, against the treatment procedure as well as the British rule, were the most common way in this resistance. There were also direct demonstrations occurred to oppose the treatment process. According to Arnold, the initial phase of the anti-plague measures demonstrated the strength and political opportunism of the colonial state and its willingness to put state power at the disposal of western medicine (ibid. 1987: 90). But the force of Indian reaction resulted in a reassertion of

political over sanitary considerations and the shift to policy of accommodation directed primarily at winning over middle-class support and co-operation. Arnold shows two different consequences of this consent project. In the short term, the subaltern classes in the towns and countryside were disposed to view the middle classes with suspicion and as allies of the British. In the longer term, however, emulation of higher-caste, middle-class ways was a significant factor in persuading the 'common people' to overcome their doubts about Western medicine and to show a greater acceptance of hospitals and inoculation than during the early plague years (ibid). Sultana calls these higher-caste and middle class as native elites and she argues that these native elites had worked as the active agent to expand western medicine as well as its supportive institutions in this region (Sultana 2004: 3).

It was the colonial period, when these native elites had justified the epidemic control 'for the betterment of health'. However, in the postcolonial time, this legacy has been sustained. Country like 'independent' Bangladesh has been used as an experimental field for 'Western medicine' (UBINIG 1990). These experiments not only exercise for the controlling or curing diseases, rather it is also going on to control populations. In the colonial period, epidemic diseases were the main concern for the controlling body but in a postcolonial era number of human beings were considered as 'problems'. For this reason, controlling body, especially female body, is being important in 'Western medicine' to control their productivity. It happens in many ways. However, it is still experimenting the new ways of contraception to invent more 'effective' contraceptives. Norplant is such a contraceptive, which has different experiments in Bangladesh to develop and implement it's contain and this will be discussed in the following section.

3. The Contraceptive: Continuation of Western Medicinal Legacy

The contraceptive issue of Western medicine has been exploring with different kinds of contraceptives and their uses. However, Norplant is a case for this paper to understand the nature of Western medicine as a means of controlling population. Norplant was developed by the Population Council in New York. It is a birth-spacing method in which

capsules are implanted in the inner side of the upper arm of woman through a surgical procedure that causes infertility for up to 5 years (Rashid 2001: 87). The history of the Norplant trail in Bangladesh dates back to as early as 1981 (UBINIG 1990:2). It was not only a trail, as there were marketing promotional activities going on. From the beginning, Norplant was promoted to the government of Bangladesh through Bangladesh Fertility Research Program (BFRP) as more effective than sterilization. Advertisements were placed in Bengali-language newspapers entitled: 'a new birth control method/ Norplant/ a wonderful innovation of modern science….. The advertisement went on the say that Norplant was for women, can be implanted under the skin of the arm, will 'ensure sterility' for five years and that its effects are reversible when removed (Population Research Institute- PRI petition 1998:4). This advertisement for the mass promotion of Norplant, while its scientific status was still under investigation, was the first attempt to initiate a Norplant trial in Bangladesh (UBINIG 1990: 2-3). Alerted to Norplant's experimental nature, women's groups in Bangladesh protested its use. Over 150 concerned doctors, pharmacists and health workers petitioned the Ministry for Health to stop the trial, which was subsequently postponed (PRI petition 1998: 4).

BFRP brought up the Norplant trail again in 1985, this time in the context of an explicit 'clinical trial' (PRI petition 1998: 4). The trial was conducted in secret, without the public announcements and advertising campaigns. After the trial had begun in 1985, BFRP began making the following claim in 1986 in its BFRP Bulletin News and Vies: The Norplant contraceptive system is suitable for most women of reproductive age (UBINIG 1990: 4).

This justification process was not only conducted by BFRP. There were many scholars inside and out side of Bangladesh who did their advocacy for Norplant. In a Egyptian study, Shaaban and others suggested that Norplant implants were an effective acceptable method of contraception with minimal side effects, and definitely deserved wider use in Egypt (Shaaban and others, 1983). Similar comments came from Ecuador. The justification is reflected in the comments: 'Our experience shows that there is substantial demand for a contraceptive with the characteristics of the Norplant system' (Marangoni and others:

1983, quoted in Hardon, 1992: 761). Even some researchers in China were happy with the high rate acceptance of Norplant by Chinese women and to the medical and paramedical personnel (Sujuan and others, 1988). Singh (1989) and his colleague were encouraged with the initial findings of their research. They claimed that the initial findings were encouraging and indicate that the implants were acceptable to the Singapore women.

Above understandings have a common voice for the promotion of Norplant. I do not have evidences from where I can claim these particular researches as fictional. But there are other researches, which have been calming for the negative implications of Norplant on female health. Resistances against this new contraceptive have also evolved. These alternative researches and peoples' resistance against Norplant bring the point of fictional attitudes of the researches, which advocated for Norplant.

After introducing Norplant in Bangladesh, it was triggered wide spread controversy and criticism. The international network of the Feminist International Network of Resistance to Reproductive and Genetic Engineering and the Unnayan Bishayak Niti Nirdharoni Gobeshonah (UBINIG) have taken up a strong position against Norplant. Scientific and demographic studies on Norplant in Bangladesh report a number of side effects associated with Norplant use. A study conducted by Akhter and others (1996) find out that a majority of the women complained of bleeding problems and a number of women complained of vision problems during the trails. One woman experienced serious vertigo 20 months post-insertion, one woman has hospitalized because of severe headaches for one week after 17 months of Norplant use, one woman complained of fever for 10 months after insertion, and one woman was hospitalized for severe anemia. In another study of 1151 clinical trial participants between 6 months and 3 years, mainly bleeding problems and other health concerns, such as feeling weak all the time, were reported as major reasons for discontinuation (Kamal and others 1991).

Besides these researches against Norplant, women made their resistance through spreading rumors. In a comparative study of four countries, Zimmerman and others noted that, Rumors reported by

participants in all countries were: (1) Norplant causes cancer and sterility, (2) the capsules migrate to other parts of the body, and (3) the breast milk of Norplant users negatively affects offspring. Common sources for these rumors were friends, family and, to a lesser extent, service providers (Zimmerman and others, 1990: 97). These rumors can be compared with the anti plague control rumors of colonial time. It was a way to fight against Western medicine. The rumors against Norplant have appeared as similar kind of resistance against Western medicine in postcolonial time. Though, these rumors were not spreading in an organized form to refuse to accept Norplant, staged from a common platform, but it has lots of importance. Scott (1985) explains this type of resistance 'as everyday from of resistance'. This resistance could contribute to challenge an establishment in a hidden way. And these resistances contributed in local level to decline the acceptance of Norplant in the community. After a long struggle in local and international level Norplant was withdrawn from Bangladesh in 2001 (Rashid 2001).

After the withdrawal, the justification process to implement Norplant has not been stopped yet. In her study, Rashid says, that '... banning a particular contraceptive may not necessarily be the solution to the problem' (Rashid 2001: 86). She argues that contraceptives are essential for the betterment of poor. She believes that although international and local groups speak on behalf of the women to ensure that there is no abuse of human rights and no exploitation of the poor target group, but in practice such organizations may be removed from the reality of poor women's lives. She supports Norplant as a poverty reduction process. She says that some of the women perceived Norplant to be the most practical and least objectionable method of birth control. She says, 'A number of the rural women who already had two to three children were looking for something that was worry free and long term. Some of them decided to keep Norplant despite its side effects, which they felt were a better option than having children'(Rashid 2001: 99). Even, she represents Norplant's side effects as 'Imaginary Illness' to address poor health seeking behavior of the village poor. But she did not compare any findings from urban conditions or from 'developed' world. Rashid emphasizes poverty to justify the importance of Norplant. This understanding of poverty does not look on the world imbalance system of economic exploitation. It

looks on number of human being as the cause of poverty which is ultimately justifying Western medical intervention for birth control.

4. Conclusion

This paper makes a link between the colonial and postcolonial condition of Western medicine. The colonial state started the establishment of Western medicine to control epidemic disease. Support and influence of princes, zamindars, officials and other middle class Indians were contributed to create the necessity of Western medicine and resolved the local resistance against Western medicine. These supports and influences of Indian 'middle class' were originated from the wider hegemonic influences of Western ideas which can be called as a wider realm of cultural and political hegemony. This realm of cultural and political hegemony still influences the postcolonial societies. In the colonial period British medicine was justified by the curing of disease, but in the postcolonial period it is even justified by the population control. Norplant is a classic example of this justification.

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