

INTIMACY, TECHNOSCIENCE AND THE CITY :
REGULATING “PROSTITUTION” IN DAKAR,

1946-2010

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Abstract

Senegal is one of the very few former French colonies that explicitly pursued the sanitary regulation of prostitution after independence; in Senegal, the legal status of sex work turns on a distinction between registered “avowed” prostitutes, and non-registered, *unofficial* prostitutes – the *clandestines*. Based on fifteen months ethnographic study in two clinics this thesis traces the changes that have taken place in the regulation of commercial intimacy in Dakar following the integration of an experimental regime at the state clinic and the creation of the identity “*clandestine*” by non-governmental organizations. Despite the enormous changes that have taken place over the course of the twentieth century, colonial sanitary regulation remains a governing “biopolitical paradigm” (Epstein, 2007), leaving its traces in the therapeutic, experimental, and affective lives of the clinics.

In this thesis I examine how racial, gender, and class *difference* is produced in regulation through (1) the racial politics of colonial policy; (2) enactments of social and individual bodies at the Enda mobile clinic; (3) how difference is written into the onto-epistemologies of molecular biology; (4) how attempts to understand and accommodate difference are attempted through bioethics and the material effects of ethical practice. I do this by paying close attention to the ethnomethods of the professionals I study and to the local historical geographies of clinical practice. Throughout this thesis I think about the feminist biopolitics that might be capable of responding to and theorizing the surprising social life of the clinics.

Keywords: Dakar, Difference, “Prostitution”, Clinical Ethnography, Irony, Feminist Cultural Studies of Science

Declaration

I, Branwyn Poleykett, hereby state that this thesis is my own work and that all sources used are made explicit in the text.

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GLOSSARY OF TERMS

<i>Animateur/trice</i>	NGO worker who coordinates (animates) community meetings (in text often translated as “social worker”)
AOF	<i>Afrique Occidentale Française</i> – French territories in West Africa encompassing Mauritania, Senegal, French Sudan (now Mali), French Guinea, Côte d’Ivoire, Upper Volta (now Burkina Faso), Dahomey (now Benin) and Niger. The federation existed from 1895 until 1960.
ANCS	<i>Alliance National de la Lutte Contre le Sida</i>
<i>Causerie</i>	Consciousness-raising conversation session addressing health topics
<i>Clandestine</i>	Shorthand for clandestine prostitute, an unregistered woman who is therefore selling sex illegally.
CNLS	<i>Conseil Nationale de la Lutte Contre le Sida</i>
IHS	<i>Institut de l’Hygiène Social</i> , Institute of Social Hygiene (also known as polyclinique de Dakar)
FHI	Family Health International
<i>Plateau</i>	Peninsular Dakar, the centre of town, the old colonial “European city”.
<i>Quartiers Populaires</i>	Working class suburbs of Dakar

CHAPTER ONE: INTIMACY, TECHNOSCIENCE AND THE CITY

Senegal is one of the few former French colonies to have explicitly pursued the sanitary regulation of prostitution after independence. While it appears that there are scattered and informal policies of colonial and postcolonial regulation in many African countries in Senegal the rights and responsibilities of official sex workers are codified and carefully observed. The law requires that providers of sexual services present themselves at regular intervals (officially every fifteen days, in practice, once a month) at a dedicated clinic, and that they submit to compulsory serological tests and gynecological examinations. 1,500 women are registered at Dakar's state clinic and just under 1,000 of those women have been consulted at least twice in the previous year (do Espírito Santo & Etheredge, 2004).

The sanitary regulation of prostitution is closely associated with high modern, authoritarian, colonial rule (Levine, 2003). In Africa sanitary legislation such as the despised "open-your-legs" exam in colonial Zambia was frequently deployed to prevent or dissuade African women from entering the "European" colonial cities.¹ It is perhaps surprising then that sanitary regulation is still on the statute books in contemporary Senegal and that those urban Senegalese women who engage in "venal sexualities" are subject to a set of laws that have their origins in late eighteenth century France. Moreover, it is surprising that sanitary regulation has survived not only the enormous political and social upheavals of decolonization and postcolonial modernization; but also the arrival of "rights-based" and "people-centred" development in the wake of structural adjustment and the social, political, and economic devastation and state retrenchment that it unleashed upon Senegal. Perhaps most surprising though, is that sanitary regulation has outlived HIV/AIDS – the epidemic which has done so much to reorganize the discourses, practice and ethics of public health in sub-Saharan Africa. Why has sanitary regulation survived in Dakar, and in what guise is it currently practiced?

¹ With the exception of the small amount of oral history work (see, for example Jackson, 2002) there is a very limited amount of data on how women in the past have thought and felt about public health reforms targeting prostitutes. There is some limited historical record which testifies to how keenly these public health reforms were resented by the women involved in prostitution. According to Anne McClintock, women who were subject to compulsory sanitary inspections with a speculum in Britain after the Contagious Diseases Act of 1864 complained of "instrumental rape" (McClintock, 1991, p. 93).

In 2008 I arrived in Dakar to try to answer these questions. I soon discovered that the survival of this late colonial policy is testament to the mutations that it has undergone over the fifty years since independence. “Official” prostitutes may still be consulted at the state clinic – a distinctive, colonial fantasy of “indigenous” adobe architecture – but the care that they receive there will be provided by a highly trained doctor paid by a bilateral biomedical research to enroll registered women into longitudinal biomedical cohort studies. The police may still search the bars and streets of Dakar for the *gennkat* “women who go out at night”, but once they find them they may be as inclined to refer them to a local NGO as they are to arrest and detain them for breaking the law. In the neoliberal city characterized by the multiplication of social contracts women must engage with and beyond the state for their care and the clinics are sites where some of this complexity is experienced.

I began to construct two ethnographic case studies at the site of two singular clinics: the Institute of Social Hygiene where official sex workers are registered and consulted, and the Enda mobile clinic, an NGO-run solution to meeting the health care needs of the problematic *clandestines* – the women who refuse to register with the state and patch together their own health solutions. I began to focus on distinct historical periods at the two clinics, historical junctures rich with possibility which I reconstructed through oral history interviewing and non-participant observation. At the Institute of Social Hygiene I focused on the years 1984-1996, the period during which the clinic hosted the “Natural History of HIV-2” research programme, coordinated from Harvard University. How, I asked, had the experimental research work been integrated into the space of the clinic and how had it coexisted with the operation of state bureaucracy? My work at the Enda mobile clinic was more contemporary and focused on the mobile clinic 2004-2010. Here I studied a different form of knowledge, the NGO-ethnographers telling stories about the complex sexual practices of non-registered women and producing, at the same time, an object for their interventions: the *clandestine*.

This thesis examines how the “prostitute subject” been “placed in this game of truth defined by knowledge” (Foucault, 1994 [1987] pp. 9-10) in the context of two knowledge cultures or “evidentiary paradigms” (Ginzburg, 1986): biomedical research and NGO ethnography. Both of these research processes are spatialized in the clinic and carried out by specifically located

professionals. I have chosen to pay attention to the historical and contemporary constitution of these new knowledges through a close study of a range of knowing subjects and the “specific and contingent assemblages of practices, materials, agents and techniques through which these rationalities operate to produce governable subjects” (Hart, 2004, p. 92).

This is not a thesis about institutions, nor is it quite a history of *mentalités*; it is an account of the flexible and heterogeneous forms of practice and affect that make up experimental work and NGO interventions. Feminists have long attended to the ways in which women’s bodies are caught up in colonial and postcolonial systems of power/knowledge, ‘enrolled’ in agendas of modernization which seek to make bodies visible, legible, and transform them into objects susceptible to being “improved” or intervened upon. Here I explore how novel NGO behavioural ethnographies produce new strategies of intervention and classification, and how sanitary regulation entwines with experimentation and “global” HIV science to produce new onto-epistemologies and new subjects of regulation.

Rather than decry the impurities that arise out of the heterogeneous practice that I study at the two clinics – these transgressions between science, state biopolitics, “development”, and gendered socialities – I am fascinated by the consequences of these complex co-productions and I treat them as local complexes of technologies that together *materialize* the “prostitute” body. These investigations trace movements between a colonial and postcolonial technology: sanitary regulation, and contribute to the study of the “effects of the technologization and the technocratisation of the city on the forms of the body, speculating about the enormous and so far undecidable prosthetic and organic changes this may effect for or in the lived body” (Grosz, 1992, p. 243). This analytical approach in turn reflects a wider shift in feminist STS, the trend that Annemarie Mol has described as the “shift to content”: “the shift from analysing the ways in which the sciences are being made, to what it is they make: the objects and subjects that emerge in the process of cutting up, dissolving, or otherwise manipulating the world so as to get to know it. The bodies enacted, the passions performed, the concerns being staged. The ontologies.” (Mol, quoted in Bauchspies & Bellacasa, 2009 p. 341).

As I briefly evoked in the opening paragraphs the (colonial) sanitary regulation of prostitution is a practice that has historically relied on race, gender, and class differences to construct its own regulatory object. In this thesis I want to explore the role of new technologies of knowledge production in working upon the ontological status of these differences as they circulate in Dakar in the context of difficult and political work around the contested category of “prostitute”. So as well as following Mol to study the enactment of prostitute bodies in the clinic, I am interested in the relationship between difference and technoscience. What is the role of racial, class, and sexual difference in the making of techno-scientific worlds? And how does this difference contribute to the production of new ontologies, new possible subjects for regulation/intervention? (see Epstein, 2011).

Feminist cultural studies of science: making difference in and with cultures of technoscience

Feminist scholars have been at the forefront of examining the failure of “malestream” (Haraway, 1994) science studies to examine the relationship between science and multiple vectors of embodied differentiation. Despite enthusiastically co-opting feminist materialist analyses for the elegance and brilliance of its theory, science studies has tended to treat gender and race as “empirical questions of the absence of presence of identifiable persons at the scene of action .. [T]hat is in a static and functionalist way” (Wajcman, 2004, p. 87).

From Cynthia Cockburn’s work on the cultural identification of technology and technological mastery with men and the masculine (Cockburn, 1985) to Emily Martin’s work on the gendered stories told about masculine agency and feminine passivity in the scientific account of conception (Martin, 1991), feminist cultural studies of science have brought to light the ways in which science reproduces dominant gender narratives. Later feminist investigations into nature-culture boundaries left feminist scholars well-placed to move towards a more substantive and radical critique of the co-production and implication of embodied differences and science. Donna Haraway showed that epistemic objects were “material-semiotic” experimentally *produced* through testing” (Haraway, 1991), and critiqued the “canonical” laboratory studies for their focus on

materialities generated inside the laboratory and their failure to address “the issue of how other practices of masculine supremacy, racism, or other forms of structured inequality get built into and out of working machines” (Haraway, 1992, p. 332). Karen Barad’s theory of agential-realism investigated the multiple entanglements of matter and meaning in the construction of technoscientific worlds, rejecting distinctions drawn between malleable “culture” and given “nature” (Barad, 2003; Barad, 2007). This work moved the feminist critique beyond social constructivism and attempts to “[separate] the good scientific sheep from the bad goats of bias and misuse” (Haraway, 1988, p. 578), and towards work that sought to examine how the sciences consumed, reinscribed, and *transformed* “realities”, including embodied differences of race and sex through their material and epistemic practices.

Allied with feminist work on the intersections between multiple axes of differentiation of race, sex, gender, class, and disability (Crenshaw, 1991; hooks, 1984; McCall, 2005), contemporary feminist studies of technoscience seeks to explore how gender “in its intersections with other sociocultural power differentials and identity markers, is entangled in natural, medical and technical science as well as in the sociotechnical networks and practices of a globalized world” (Åsberg & Lykke, 2010, p. 299) Feminist cultural studies of science have studied the ‘gendering’ of technological artefacts from hormones (Oudshoorn, 2000) to robots (Robertson, 2010).

In this thesis I pay close attention to embodied differences of gender, race, class, and location, while attempting to express the role of these intersecting differences in co-constructing subjects. I draw upon a Deleuzian approach to difference as irreducible either to identity or to power and I take particular pleasure in this work in drawing on feminist theory on sexual difference which has thus far been neglected in feminist cultural studies of science, in particular the work of Irigaray, Braidotti, and Clare Colebrook. Clearly racial and sexual difference enables violent and coercive asymmetries of power based on the denigration and the disciplining of certain embodied others, and these embodied differences (even those more plastic differences such as body shape, gait and comportment) are “sticky”: they “stick to us, or become “us” as an effect of how it sticks, even when we think we are beyond it” (Ahmed, 2004). However, the complexity of the two clinical case studies undertaken in this thesis is that through the production of knowledge micro-expressions of difference are converted into an identity (“prostitute”) which is not only an “shameful” or

“stigmatized” identity, it is also one which the women involved in “interested” or partly-instrumental sexual relationships *do not recognize*. This case therefore does not fit well within the parameters of a feminist politics based on a “drive to identity and recognition and self-affirmation” and possible paths out of this identifying work could be better identified by Elizabeth Grosz’s “politics of acts not identities” (Grosz, 2005, p. 186), or a post-humanist theory of the subject such as Braidotti’s “nomadic subjectivities”. I explore some of these approaches through an analysis of the empirical data and think about the processes through which the subject is crafted as a ongoing passage through interlinked differences; “a nomadic wandering through ever changing positions and apparatuses” (Grossberg, 1987, p. 38).

I also bring feminist cultural studies of science together with postcolonial science studies, seeking to build theory that is sensitive to the power saturated differences that are implicated in assembling experimental publics for colonial and postcolonial science and aiming at a “detailed, concrete investigations of the manifestations and makings of postcolonialism” (McNeil, 2005, p. 109). Postcolonial science studies have focused on the centrality of ‘triage’ as a colonial governmentality through which populations are classified and made to matter (Nguyen, 2010; Visvanathan, 1988). Vinh-Kim Nguyen writes: “In order to govern a population by an exceptional AIDS response, that population must first exist and be available, which is not the case when the vast majority of the potentially HIV positive population has minimal access to health care, let alone HIV testing. That population must therefore be called into being through procedures that allow it to be identified, separated from those who are not subject to intervention, *and* counted – in other words, a systematic triage.” (Nguyen, 2010, p. 178).

The state system of sanitary regulation is a form of classic colonial triage based on racial science and the desire to make colonial bodies optimally productive, to prevent sexual contact between races, and to uphold colonial “prestige”. Sanitary regulation is an expression of a colonial order which had made “epidermializing into a dominant principle of political power” (Gilroy, 1998 p. 847). The forms of triage that I study at the Institute of Social Hygiene and the Enda mobile clinic *mobilise* and *produce* new forms of difference, although, as I examine in chapter seven, race is powerfully implicated in and articulated with novel forms of difference. In other words difference is both integral to the creation and contouring of “prostitute” identities and is also produced

through the knowledge projects than enact “prostitutes”. In this thesis I see difference as a “stuttering that ‘no longer affects pre-existing words, but, rather, itself ushers in the words that it affects” (Dewsbury, 2000, p. 476).

Dakar

The history of the regulation of prostitution in Dakar is an intimate history of the city: its urban forms, its social and economic inequalities, and its history of political identification and organization. In order to understand the practice and organization of commercial sexuality in the city it is necessary to comprehend the historical and social forces that have shaped urban life on the Cap Vert peninsular, including natural disaster, structural adjustment and political disenchantment.



Figure 1 Map of Dakar and its *banlieues*

Ranked 156 out of 177 countries in the UNDP Human Development Index, Senegal is an extremely poor country. At independence the Senegalese economy was heavily reliant on groundnuts, the colonial cash crop. In the 1970s following the decline of the value of the peanut crop and a series of severe droughts the Senegalese government were forced to approach the IMF for assistance. In 1983 Senegal embarked upon a programme of structural adjustment which created the conditions for the current economic situation, referred to in Senegal simply as *la crise*. Employment in the formal sector contracted swiftly and dramatically; adult employment is today roughly 50.7% for men and 37.7% for women. The rampant informality of the labour market in Dakar has resulted in an extreme precariousness of daily life. The majority of the population survive on the fluctuating earnings from informal economic activities and money from a patchwork of sources, including *tontines* (group saving accounts), remittances and informal interpersonal loans (Guerin, 2006). The struggle of the Dakarois to make ends meet is represented in the wildly popular cartoon strip and later television show *Goongoorlu*, whose eponymous hero, the Senegalese everyman is affectionately portrayed in constant pursuit of la DQ (the daily expenditure). The persistent failure of the Senegalese state, despite its developmental pretensions, to secure the basic needs of its citizens has given rise to the practice known as of *vivre Sénégalaisement*, meaning to improvise a living beyond the boundaries of a state that cannot be relied upon to provide any support for its citizens (Cruise O'Brien, 1989). Urban survival is dependent on a “*culture de la débrouille et du bricolage*” (Dimé, 2005), a culture of getting by through ruse, improvisation, and cobbling together resources out of the scant materials available.

Senegal under the leadership of opposition renegade turned NEPAD founding member Abdoulaye Wade is one of the more classically neoliberal countries in sub-Saharan Africa. Since the *alternance* – the change of leadership from the *Parti Socialiste* to the *Parti Democratique Socialiste* – in the year 2000 the country has struggled with an escalating urban infrastructure crisis – including floods in Dakar's largely informal *banlieues* which have necessitated the rehousing of large numbers of the population; an ongoing an escalating urban energy crisis exacerbated by the part-privatisation of the electricity company *Senelec* and sharp spikes in the cost of essential food products and gas – a product of the Sahel's deeply worrying dependency on imported food which left it horribly exposed to food price rises in 2007/08. These developments have taken place against the general

fabric of *la crise*, the “crisis”, the name given to the extreme precarity of urban life engendered by mass unemployment and the steady increase of restrictions on the possibility of migration to Western Europe which had long kept households in Dakar afloat.



Figure 2 Neoliberal street art on the Corniche: “Nepad Mo Ko Yor” (“Nepad is the Greatest”)
(Photograph: Poleykett)

The response of the Wade administration to these acute social and economic problems is generally judged to have been thoroughly inadequate. The main axes of state urban intervention in Dakar have focused on infrastructure development, prestige projects such as the hosting of the Islamic Fair in 2008 (overseen by Wade's enormously unpopular son and beset by allegations of widespread corruption and embezzlement), and the construction of expensive urban monumental space along Dakar's West coast which culminated in the construction of the radically unpopular

and internationally ridiculed *Monument de la Renaissance Africaine* (on which Wade spuriously claimed 35% of visitor-generated profits as “intellectual property rights”). The flagship social project of the Wade era has been the construction in Dakar and throughout Senegal of a network of *case de tous petits* (the little one's houses), a development project centered on increasing human capital in children under six and in investing in Senegalese mother's knowledge about early childhood. The contrast between this (classically neoliberal) investment in early childhood and his wholesale abandonment of the young people of Dakar could not be starker.

In addition to the extreme disillusionment with the ruling PDS party, many Senegalese are angry at the not inconsiderable damage that has been done to Senegal's international reputation as a democratic “success story” by Wade's authoritarian and personalized style of rule and the allegations of corruption, cronyism and outright political violence that have beset his administration. Resentment towards Wade on these counts focuses in particular on his grooming of his son Karim for the presidency in 2012 which has been noted by donors and the foreign press as a dangerous drift away from Senegal's cherished democratic principles. In the face of these anti-democratic tendencies and his apparent disregard for the suffering of ordinary people – particularly the 2 million in Dakar – largely poor, young, and precariously employed, Wade's practiced populism has lost its shine. This disillusion has resulted in an unraveling of trust and a weakening of the social contract between representatives of the central and decentralised state and the people evidenced by a steady increase in violent clashes in Dakar between the citizens and the army over constitutional change and electricity cuts.²

These political and economic changes and the telos of *crise* in Dakar which reflects the consistent and on-going decline in people's spending power and standard of living has created a culture in which “hopes for the future, and people's adjustment to reality are exerted through a morality that is often animated by despair” (Fullwiley, 2010, p. 642). The pauperization of the lower and middle classes in Dakar is woven through people's daily experience and materialized visibly in changing urban practices such as the visible sale and consumption of “poor food” *pain restant* (the leftover

² <http://www.guardian.co.uk/world/2011/jun/24/senegal-abdoulaye-wade-election> ;
<http://www.guardian.co.uk/world/2011/jun/28/senegal-power-cuts-riots-troops>

stale baguette) *fonde* (millet porridge), *ndambe* (bean sandwiches), and *yaaboy* (cheap sardines in the main rice dish of the day) (Dimé, 2005); or in caustic references to *Article II* – the practice of cutting down the traditional three cups of tea to two (Foley, 2010).

In chapter four I further explore the impact that these economic and political changes have had upon the social life of the economy (Roitman, 2005), and the ordering and experience of social, kin-based, inter-generational and sexual relationships in the city. In particular I discuss the gendered experience of youth culture which valorises the masculine “getting on” of the “xoosloman” - indeed attaches to that a curious value both ascetic and acquisitive – but groups young women's affective speculation under the general neoliberal anxiety that “things are not as they appear” (Shipley, 2009 p. 549).

Healthcare in Dakar

Throughout this thesis I examine the choices that women make: “choosing” registration, being part of research work at the Institute of Social Hygiene, and transacting with the mobile clinic programme for their care and follow-up. Clearly, those choices are radically constrained by the non-availability of acceptable forms of care at other clinical sites in the city; what other treatment options do these women have? Lack of access to biomedical healthcare is often defined purely in terms of the existence of resources and an assessment of the financial feasibility of accessing those resources for the poor. However, Abou Salam Fall’s research in Dakar shows that the urban poor are often unaware of where to go for treatment and increasingly reject the care that is available judging that care in hospital and clinics is “not for people like us”, or citing doctor’s lack of *yermaande* or compassion (Fall, 2007). Jaffré observes that while Africans living in cities benefit from “privileged” access to a range of care compared to their rural counterparts, urban dwellers must also negotiate “une offre de santé biomédicale d’une extrême complexité” comprising a range of public services, private and nongovernmental services (secular and religious), and “non-profit” services (Jaffré, 1999). Making one’s way through this system can be extremely difficult for those who do not know an insider and people frequently experience anxiety that services might involve hidden charges, or that they will be kept in hospital against their will running up enormous debts. Moreover, seeking a biomedical consultation and diagnosis is not helpful if the outcome is to be

prescribed a list of expensive medications only available from a pharmacy. Many women who use the clinics in this study supplement the biomedical care that they receive with traditional medicine and drugs purchased at the markets.

Trying to keep oneself and one's family healthy in Dakar is a constant battle and most Dakarois live in constant fear of falling ill and needing care. For the women in this study contracting with the clinics involves accepting a new identity, even if partial, secret, and often a very small part of these women's lives. However, if they receive in return free or subsidized medical help and some guaranteed continuity of care and support; they often judge that trade-off to be worthwhile.

The regulation of “prostitution” in Dakar: a short history

The “regulation” of prostitution is a generic term which refers to the involvement of the state – in any capacity – in the transaction of commercial sexual contracts between its citizens. “Regulation” also refers in a specific historical sense to the sub-set of health governance that was finessed into a science of public administration in the mid to late nineteenth century and which is closely associated with the city of Paris and with the pioneering social and scientific taxonomy of urban prostitution carried out by Parent- Duchatalet in the early nineteenth century. Parent-Duchatalet's work was to become the point of reference for regulation across Western Europe including the formulation of the British Contagious Diseases Act of 1864 (Walkowitz, 1992). He argued that prostitution should be regulated in order to strategically restrict access to public space for women suspected of being prostitutes. His text also betrays a deep concern with the “permeability of the boundary between the prostitute and non-prostitute body” (Bell, 1994, p. 50), an anxiety which, as I examine in chapter four, is very deeply felt in contemporary Dakar.

In more “enlightened” times, “regulation” may refer to a set of flexible practices which have expanded to include social outreach, protection from violence, and the provision of specialised health services for sex workers. Whatever form it takes the regulation of female commercial sexuality is a historically contingent form of intimate governance which powerfully reflects and refracts some of the most live questions in public health. How can human rights be accommodated in an epidemic? How can state and non-state actors manage the care of citizens who engage in

potentially highly stigmatised behaviours? Who does and who *should* assume responsibility for providing basic health services in African cities?

Metropolitan Regulation

The story of sanitary regulation in post-war Senegal begins in interwar Paris. French authorities had developed a range of tactics targeting “public women” which were considered entirely banal throughout the late eighteenth and nineteenth century. Peter Baldwin in his comparative history of state sanitarianism in Europe writes: “prostitutes were public women and regulation was the public health measure appropriate to the situation... [I]nspecting them for disease was no more degrading than checking the calibration of a bartender’s glasses” (Baldwin, 1999, p. 361). However, by the early twentieth century politicians and municipal officials were no longer persuaded of the efficacy of regulation for controlling the spread of disease. Rapid social change and the increased presence of women in urban public spaces were making segregationist policing tactics obsolete. Alain Corbin in *Women for Hire* (1990) cites Leon Bizet writing after the First World War: “Prostitution is no longer confined to the bottom end of society and its oil stain is spreading upwards. Which is the marquise, the wife of the immensely rich industrialist, or simply the woman of easy virtue? *What an embarrassing question* and what a difficult problem to solve” (Corbin, 1990, p. 336).

If concerns had been voiced in the first decades of the twentieth century about the use the blunt instruments of sanitary regulation as a prophylactic in a rapidly changing urban society, French public opinion turned decisively against regulation in the aftermath of the Second World War when women who had been practically imprisoned in the official *maisons closes* were branded collaborators, accused of sleeping with the occupying army. A high profile campaign led by a former prostitute Marthe Richard was waged against the tolerated brothels and in 1946 the *Loi Marthe Richard* ordered their closure.

The passing of this bill brought to an end a period during which France had become known as the home of regulationism and the ‘French system’ was much debated and experimented with across Europe. Alain Corbin’s classic study *Les Filles de Noces* (1982) examines the rise of regulationism, locating it in the politics of late eighteenth and nineteenth century France and Paris in particular. He traces the ascendancy of the ‘sanitary alibi’ (Corbin, 1986: 210), particularly pronounced in the

nineteenth century and argues that one of the ironies of this exemplary ‘modern’ urban policy is that is based on pre-Pasteurian mythologies and is structured by an archaic definition of health and disease’ (210).

However, the passing of the *Loi Marthe Richard* was not the watershed moment it had seemed. The bill was swiftly followed by the *Loi du 24 Avril 1946*, which established a social and sanitary register, of which Alain Corbin observes: “it amounted to centralizing information collected on prostitutes, assisting the hold exerted by the “milieu” and above all preventing women from “disappearing”. The setting up of the file, which would be confidential only in theory, affecting what, for the prostitutes, had hitherto been the most effective mode of freedom – that is to say, the ability to move about or to merge into the population of a large city and thus move back into society – was the supreme refinement of panoptical procedures” (Corbin, 1990, p. 336). Alain Corbin then concludes his discussion of “Taylorized prostitution”, and the “Golden Age of Surveillance”, with the following observation on the end of the sanitary era on Western Europe which looks forward to France becoming, in the second half of the twentieth century, the most vociferously abolitionist country in Europe: “Sanitarism... was already anachronistic when it was established in its ultimate form in 1946. It could not be maintained for long, and ... the surveillance and marginalisation of the prostitute would have to be based on other arguments. From this point of view, the legislation of 1960 introduced a new period: *our own*. From now on, it was the struggle against procuring and not the fight against venereal disease that, by subtle reversal, was to make it possible to keep the prostitute outside common law.” The legislation of 1960 was a response to the post World War Two rights regime in Europe, which found the sanitary regulation and compulsory inspection of sex workers to be inconsistent with principles of human dignity, newly codified in law (Maffesoli, 2008). This new moral landscape would be further shaped by the humane “deinstitutionalisation” of welfare services (Gleeson & Kearns, 2001) and the beginnings of the feminist and sex workers’ rights movements across Europe.

However, Senegal gained independence in 1960, and the legislation of 1946 – the culmination, as Corbin argues, of years of state sanitarianism, hygienist discourses, and police practice – was never

taken off the books. The legislative shift of 1946 was the beginning of a complex postcolonial story in Senegal which this thesis reconstructs.

Postcolonial regulation

The story that I am going to tell about postcolonial regulation is divided for the sake of clarity into three roughly linear phases which also correspond to the first, second and third empirical chapters of this thesis. The first phase relates to the particular colonial conditions under which legislative approach to sanitary regulation was developed, and the postcolonial codification of this legislation in 1969. The second phase deals with the discovery of HIV-2 in a blood sample taken from an official prostitute registered at the Institute of Social Hygiene (*L’Institut de l’Hygiène Sociale – IHS*), the subsequent investment in bilateral biomedical research programmes at the site, and the growth of a radical, sex worker-led outreach programme. The final phase deals with the problematisation of *clandestinité* – the name given to the strategies of young women who resist state registration – and the policy that NGOs sometimes call the *stratégie avancée*, the provision of specialised care away from the static state health structures, targeting specific “hard to reach” communities, and using novel intervention methods. I take one intervention, the Enda mobile clinic, to be exemplary of this strategy and I study the programme which recruited non-registered sex workers in Dakar between 2004 and 2010. These three phases are non-discreet, the last two are roughly contemporaneous although spatially distinct and narrated by actors in the field as belonging to distinctively different scales of intervention.

The Institute of Social Hygiene

The *Loi du 24 Avril 1946* was promulgated simultaneously in metropolitan France and in some French overseas colonies. Although it was a metropolitan policy, in Senegal it was continuous with the colonial administration’s strategic aims for managing commercial sexuality in the city. The circulation of this metropolitan policy chimed with the general anxiety about “native” women’s sexual health which gripped colonial administrators in Dakar and elsewhere. This administrative project was considered increasingly urgent in the 1940s, as the French pursued a late colonial policy of “stabilization”, and women were allowed to settle in the colonial city (Echenberg, 2002). This invitation was officially only extended to women joining their husbands, but there was increasing concern about “unaccompanied” women in Dakar. The new legislation was also

consonant with the change of colonial sanitary policy post World War One which was moving from treatment to a “social” preventative medicine.³

Plans had been circulating for some years prior to the passing of the two bills which reshaped regulation for the establishment of a clinic dedicated to the treatment of venereal disease in the *quartier indigene* which adjoined peninsular “European” Dakar. This clinic, the *Institut de l’Hygiène Sociale* was established for the treatment of “social” diseases including tuberculosis and alcoholism; here the registered sex workers were treated and their details were held. It was no coincidence that the Institute of Social Hygiene was also designed to replace the old “native” maternity hospital. With the invention, in 1906, of the Wasserman test for syphilis, the colonial authorities across the French empire focused their energies on the treatment and prevention of venereal disease with a particular accent on mother to child transmission and the eradication of congenital syphilis (Wright, 1991).



Figure 3 L’Institut de l’Hygiène Social, Medina, Dakar

Following Senegal’s independence in 1960, the *Loi du 24 Avril 1946* remained on the books –

³ « L’assistance médicale curative doit céder le pas à la médecine préventive sociale » (Circulaire Ministérielle du 10 Décembre 1924, cited in Becker & Collignon, 1999, p. 138)

although there is some uncertainty and lack of clarity about what happened at the Institute of Social Hygiene in the decade following independence. The next major legal development was the first codification of this system in 1969 and the law has remained almost unchanged ever since. Whilst it remained legal for *official* sex workers – those who were registered with the state – to sell sex provided they did not break any of the rigorous laws on soliciting, this bill gave police more powers to prosecute women and knotted the legal and sanitary systems together a little closer than they were before. The most characteristic feature of the bill is the stress that it lays upon the sanitary agenda. It repeated urges pragmatic policing, underlining the fact that the priority of regulatory activities is not *primarily* the establishment of preservation of a moral order, but that as many women as possible should be brought into contact with the state system.

Official sex workers continued to be consulted at the IHS which remained at the same site in its distinctively “Sahelian” style colonial-era building. Interviews with staff at the Institute, some of whom have been employed there since the early 1970s reveal that the purpose the regulatory system during this time was primarily “social”. Women were registered, given basic advice and had their STIs treated in a rather rudimentary fashion following pelvic examinations. Women were consulted by social workers and nurses and very rarely saw a doctor. Although the clinic staff kept the paper records diligently up to date and systematically tested for and treated the women for syphilis infection, the general impression was that the system was unwieldy, a little out of date.

However, the population of registered women had attracted the attention of Professor Souleymane Mboup, a young virologist at Dakar’s University Cheikh Anta Diop, who worked alongside Dr Ibra Ndoye – a gynecologist by training and the head of the Institute of Social Hygiene. Together the two men conducted exploratory pilot studies into levels of STI infection among the registered women, although they were often frustrated by the poor laboratory resources in Dakar at the time. When USAID arrived in the late 1970s with a large Family Planning grant, Mboup, Ndoye, and others, decided to leverage that funding to build up laboratory capacity. They argued that in order to set up and run Family Planning programmes they needed to have “*une certain maitrise dans la santé de la femme*” and in order to do this they would need to be able to manage cohorts and test for STIs. Because of this lobbying, FP funding built an impressive laboratory – the best equipped facility in West Africa – and contributed to the training of a cadre of young virologists.

The discovery of HIV-2

In 1983 Souleymane Mboup began looking for the new virus which had been recently identified in the US among urban gay men. Acting partly on the basis that there were relatively credible theories that the virus was sexually transmitted – and also partly pragmatically working with populations that were easy to access – Mboup tested registered sex workers and patients hospitalized in cancer wards in Dakar. As Mboup noted, he was able to test these women, stay in contact with them, and trace the sample with great accuracy, “because I was already used to working with that population – we had mapped already, you see, so it was very easy for me to get a cross-sample” [Interview: SM]

The coincidence that Mboup stresses here refers to the serendipitous combination of an efficient bureaucracy already in place because of the regulatory system; women socialised into giving blood frequently who understood testing as being part of the social contract of the clinic that bound them to the state. These particular ideal type situations have emerged elsewhere at the junctures of particular “natural” and socio-historical processes, for example Beth Greenhough examines the scientific exploitation of the island geography of Iceland (Greenhough, 2006b); Nikolas Rose draws attention to the combination of factors that allowed the post-Soviet Baltic states to emerge as genomic pioneers: comprehensive medical and genealogical records, stable populations, and several unusually prevalent medical conditions (Rose, 2008).

Mboup sent a sample to Max Essex at the Harvard School of Public Health. The team in Boston analysed the sample and concluded that it was a virus with a distinctive structure which appeared to be quite different from the recently discovered HIV-1. In fact, when the sample was tested it was mistaken for a sample from a primate (it was marked “S” for Senegal, which was thought to stand for “Simian”), because the molecular structure of the virus was so unusual.⁴ The Harvard team then funded a large research laboratory in the Dantec hospital in Dakar and put Professor Mboup at the head of a trained team of virologists. Unfortunately the Harvard/Dakar team were working with samples “inexplicably” contaminated with Simian Immunodeficiency Virus, and so failed to correctly isolate HIV-2 (see Figure 2 below). The credit for the “discovery” of the virus therefore

⁴ As I go on to explore in Chapter Five, this is a story which has a lively counterfactual circulation at the Institute of Social Hygiene and among scientists and clinicians.

belongs officially to Luc Montagnier at the Pasteur Institute in Paris.⁵

SCIENCE

Laboratory mix-up solves AIDS mystery

Steve Connor



Monkey mix-up in the lab

TWO LEADING AIDS researchers have admitted that they made a serious mistake in their work with viruses that seemed to cause immunodeficiencies in humans and in monkeys. Robert Gallo and Francois Koenig, both at the US National Institutes of Health in Bethesda, and at the Harvard School of Public Health in Boston, accept that they had isolated two different viruses, HTLV-4 and a monkey AIDS virus, which they had mislabelled as another monkey virus, called SIV, which they had received from other researchers. The researchers had made the "discovery" of HTLV-4 in an article in *Science* in 1983. They had then tested the virus in monkeys taken from Senegalese prostitutes. Several months before this, in 1982, they had reported the discovery of an AIDS virus in African green monkeys, which they called STLV-3. The researchers have now admitted over what to call AIDS viruses. Robert Gallo told *Science* that he had been asked in Bethesda, and that the virus belonged to the family of viruses called the HTLVs, the same family as the AIDS virus. He therefore called the first AIDS virus HTLV-3, while the second virus he had isolated he called HTLV-4. Similarly, the simian AIDS viruses were called STLVs.

At the time of the "discovery", an international committee of virologists ruled in that the AIDS virus in humans should be called HIV (human immunodeficiency virus), and the monkey virus (simian immunodeficiency virus). Gallo and Essex, however, had called the AIDS viruses HTLV-3 and HTLV-4.

Just before Essex's paper on HTLV-4 appeared in *Science*, Koenig, at the Pasteur Institute in Paris gave a lecture at a Poxvirus meeting in Paris about the isolation of a new AIDS virus, which he had discovered in 1983. At the time he called this LAV-2 virus. In 1985, he called it HTLV-2. In 1983, called LAV-1. This virus, subsequently called HIV-2, was the same as Essex's HTLV-4.

It is now known that they are not the same virus. Essex and Koenig made a mistake in mislabeling the AIDS virus as a monkey virus that they had received from researchers from the New England Regional Primate Research Centre in Massachusetts that contaminated their cultures

from the blood. Inexplicably, SIV contaminated these blood samples, and the two mislabelled viruses for what was causing the production of antibodies in these samples. A similar mistake may have occurred in his earlier isolation of STLV-3 from African green monkeys.

Both researchers say that they have molecular genetics at the University of Massachusetts have now solved the mystery. This episode should serve as a strong warning for all virologists to be extremely careful when testing any new isolates against viruses present in the laboratory. If an aware, or has been, used, tested for viruses in other laboratories in the US and Europe where non-HIV-1 viruses are also being tested with HIV-1 in the same containment hood.

Some AIDS researchers suspect that Montagnier's claim to have discovered HIV-1, which he made in 1983, was a mistake. Montagnier, who was not available for comment last week, was referring to an article in *Science* in 1986, which was announced by Robert Gallo in 1984, which he called HTLV-3. A strain of this virus was later isolated by Gallo, and he claims that Montagnier discovered it a year earlier, in 1983. Montagnier has also been given to Gallo on two occasions (*New Scientist*, 12 February 1987, p 49).

Montagnier and Gallo shared the 1986 Lasker Award, one of the US's most prestigious medical awards, for their work on AIDS viruses. Essex was the award party for his discovery of HTLV-4 and Koenig and Gallo for his discovery of HTLV-3. □

Sex' lethal gene decides gender of fruit fly

A GENE called sex lethal decides whether a fruit fly will become a male or a female. The gene controls the way in which genes produce proteins. It does this by making proteins that regulate the way other genes are converted into proteins.

Sexual differentiation in fruit flies, such as *Drosophila melanogaster*, is controlled by genes being turned on or off. According to Kessler and colleagues, from Princeton University in New Jersey, the differences between male and female fruit flies are controlled by the sex lethal gene. It is not known whether the sex lethal gene is active or not, but in the female it is active, while in the male it is not.

The cell first reads the ratio of X-chromosomes to autosomes—chromosomes that are not sex chromosomes—and decides between male and female.

Figure 4 "Monkey mix-up in the lab" New Scientist, 25 February, 1988, Vol 117: 1601-108

Isabelle Stengers writes that we should ask several key questions of "scientifically well-established" phenomena: "[W]hat is the scope of its testimony? Whose history or possibilities should be compelled through it? (Stengers, 2000, p. 50). She suggests that scientific developments can set in train a cascade of different chains of action and consequence. They may only influence a very small number of people – a specialised cohort studying a local or isolated phenomenon. Equally, a scientific development like the Copernican revolution can revolutionise widely held ideas. Such changes may also be used to leverage funding and to build cases for the reorganisation of research fields which have wide-ranging consequences. Finally, Stengers notes, "a scientific work can .. involve and speak to a new technico-social ordering of the city, provoking an alliance with those who might be invested in such an implication" (*ibid*, my emphasis). My interest in the discovery of the HIV-2 virus and the mapping of the "world's 'other' HIV epidemic" (Gilbert, 2010), relates to this role that it played in the re-ordering of the city and the relationship between the new "molecular" research order, and the old "municipal" regulation order.

"Everybody wants to be on our team" The NGOs and the *Clandestines*

⁵ Professor Souleymane Mboup had a very difficult working relationship with the *Institut Pasteur de Dakar* during this period.

To tell the final chapter of the story I am going to have to change tack a little and contextualise these events in relation to the state response to HIV/AIDS. This last phase of the story of twentieth century regulation is about the state and the NGOs. In the period immediately following independence the authoritarian Senghorian state carefully controlled the number of non-government associations. In the early period of Abdou Diouf's presidency and in the first phase of liberalization the state entered into open conflict with NGOs. Since the mid-1980s, however, the state has actively encouraged and enabled the proliferation of NGOs and associations and Senegal has "experienced [an] explosion in the number, density and variety of voluntary associations" (Gellar, 2005, p. 99).

In the last 5 years in Dakar there has been an increasingly visible public and policy discourse about non registered sex workers' non-compliance with state regulation⁶. A survey conducted in 2005 found that an estimated four fifths of women involved in commercial sexuality in Dakar were clandestine, that is to say unregistered and therefore working illicitly. In a 2003 study of clandestine sex workers a variety of different reasons for non-registration were given "ranging from a lack of knowledge to a simple refusal" (Laurent, 2003, p. 1815). A 2002 report by the Senegalese health ministry found that almost 20% of their sample was aged less than 21 and therefore ineligible for registration. A further 13.6% were not able to register because they lacked identity documents (Homaifar and Wasik, 2005).

The phenomenon has attracted interest from researchers, politicians and international and national NGO staff, and the debate coalesced around how these recalcitrant women would be best reached and what kinds of outreach work could be best adapted for their needs. Some researchers have focused on the ways in which state regulation could be reformed and liberalized. Bougazelli for example, strongly advised that the minimum age of registration be lowered from twenty one to eighteen in order to bring younger women involved into the milieu into the formal system (Bougazelli, 2006). In their study conducted at the Institute of Social Hygiene Homaifar and Wasik

⁶ See, for example, *Prostitution et VIH/SIDA : De la nécessité d'adapter les textes aux réalités actuelles*, http://www.lesoleil.sn/article.php3?id_article=31033; *Plus de 80% des travailleurs de sexe évoluent dans la clandestinité, 25% atteintes du VIH/Sida ENDA TIERS MONDE TIRE LA SONNETTE D'ALARME* <http://www.xibar.net/index.php?action=article&numero=9634>; *Série de plaidoyers en faveur de l'amélioration de l'environnement juridique de la prostitution*, http://www.aps.sn/aps.php?page=articles&id_article=43009 .

concluded that “more efforts must be made to make the *availability and necessity of registration* more apparent to sex trade workers. By effectively implementing more education and outreach programmes, many women who continue to operate as *clandestines* may become more aware and willing to take part in the public health system and take advantages of the many physiological and social benefits it provides” (Homaifar & Wasik, 2005, p. 124 my emphasis)

Other NGOs however, including those who conducted the first pioneering research into clandestine sex work in the *banlieues*, began to formulate a series of recommendations that went beyond changes to the legal framework of state regulation and sought instead to stress the manifest insufficiencies and organisational problems associated with the public system. In steering committee meetings a consensus gradually began to emerge suggesting that if the sex workers would not go to the state, the NGOs would have to go to the sex workers. Although the NGOs stressed that they were not prepared to duplicate the functions of the existing state structure, they could, they argued, reach women whom the public system; clumsy, bureaucratic and seemingly incapable of censuring the (reputedly) hostile and stigmatizing behaviour of its functionaries, would never be able to engage. The natural advantage of NGO actors over the state in this case seemed clear. The problem was urgent and urgently needed the kind of funding that donors swiftly made available when they shared data that they gathered which put HIV prevalence amongst clandestine sex workers at around 30%. The Senegalese state, which continues to operate its enviable health infrastructure on a scarcity budget, could not have raised the kinds of funds that the NGOs attracted; funding that equipped and ran whole mobile pharmacies. Furthermore, now that the existence of unregistered sex workers had been acknowledged and the level of HIV prevalence among this group had been established it was argued that the system could no longer rely on women’s self-identification and voluntary presentation at the clinics. Sex workers, it was argued, must be allowed to continue to work in *clandestinité* and granted access to the services that the state provided: (non-voluntary) HIV testing and the diagnosis and subsidized medical treatment of sexually transmitted infections. All of these services could be more effectively offered by NGOs, the argument goes, because they were more flexible, more secular and more democratic, both in their internal structures and their organizational values.

This conclusion is, of course, consonant with the broad consensus around the ‘comparative advantage’ of NGOs over the state in the global South, and particularly in Africa, where the market is not yet developed to the point at which it can play a role in the provision of basic social services. The paradigmatic intervention carried out by NGOs with clandestine sex workers was the Enda mobile clinic, signalled out for praise in every UNAIDS report, it was largely due to the positive reception of this innovative programme that Enda won the ‘Red Ribbon’ award in 2006. This strategy – going to find unregistered sex workers and providing them with care that came with, if not none, then *less* conditions attached – is called by some NGOs (although not Enda) the *stratégie avancée*; “advanced” in the sense that it has gone beyond or exceed the possibility represented by the old ‘localised’ care model of the regulatory system.

The advocacy work carried out by a group of NGOs working alongside Enda: including FHI (Family Health International); ANCS (Alliance National Contre le Sida)⁷; and AWA, succeeded in highlighting and problematising the different strands of “vulnerability” of the *clandestine*. Although research was carried out into the complex phenomenon of *clandestinité* before the NGOs picked it up in the early 2000s, the NGOs must still be considered responsible for the current exceptionally high level of awareness of the problem of clandestine sex work. This culminated in a series of small triumphs, notably the inclusion, in the 2006 *bulletin épidémiologique*, of a separate category – *les clandestines* – and the HIV prevalence amongst this group.

The *clandestines* are exceptionally good clients for the NGOs. The problem of clandestine sexuality appears to be lodged at a particular scale, at a sticky juncture between a familiar (and attractive to donors) narrative about state abandonment, a moral, “culturally specific”, and economic problem which lends itself to NGO theorising and to NGO politics. The jostling for “clients” in Dakar has reached the point where the mobile clinic project that I write about in Chapter Six has very recently stopped operating in Dakar. When asked why the project manager replied: “There is too much competition in Dakar, and I am not interested in competing, I am interested in doing innovative work”.

⁷ The ANCS has been a close partner of Enda for sometime; the ANCS in 2004 were granted the right to disburse the Global Fund, a decision which was treated as a coup for Senegalese civil society.

The reactions of the young women “prostitutes” themselves to this extraordinary interest and instrumentalization of their lives varies from nonplussed, to cautiously optimistic about the opportunities this might bring, to frankly hostile. Many would agree – following Arundhati Roy’s critique of the NGO-isation of politics in India – that the “adoption” of *clandestines* as a key NGO constituency threatens to turn difficult resistance and solidarity with economically marginalised sex workers into “a well-mannered, reasonable, salaried, 9-5 job. With a few perks thrown in” (cited in Benson & Nagar, 2006, p. 582). At the state clinic I met Maty, a young sex worker who was trying to establish a support group and finding herself “crowded out” of a busy market of empowerment. “Who are they?” she asked; “they go to their meetings and then at night they go home to their families, *at night we go out!*”

Research questions

Above I have made several observations about the changing shape of regulatory practice and the progressive incorporation of new, non-state actors. These observations seem to tally with AbdouMaliq Simone’s observation that in the contemporary African city “technologies and apparatuses appear to supersede systems of control based on confinement and subjectification – what one might call the changing of the guard from the “old school” to the “new school”. This new school does not so much supplant or erase the former logics of urban regulation as much as it repositions them in terms of multiple countervailing powers” (Simone, 2004, p. 112).

If, as I hope to show in this thesis, these observations about institutional shifts are valid, then these changes present several provocative questions. Firstly it asks how *biopolitical* matters are being interpreted, accomplished, and refracted through the systems and apparatuses of new actors. However we can assume that as the buildings are still standing, the institutions still functioning, that the regulatory order has not been expunged, some traces of it will remain – but where? Are the pretensions of the colonial and postcolonial modernisers preserved in the current arrangements? Or is modernisation exemplified by the *will to improve* (Li, 2007) the health and lives of everyone in the city, the assembled “social body”; simply no longer an objective of health professionals holding together ragged and fragmented systems? It also remains to be asked *who are these actors*; where are they situated; how are they positioned by the contexts in which they work. What is important to them? How do they know if they are good at their jobs? What does it mean

to them to do “*good work*”? I follow of these lines of inquiry in tracing regulatory histories and their materialisation at the site of the two clinics that I study.

In the two empirical case studies I follow the same process of analysis working through four questions at each site. (1) How do the institutional arrangements of the clinic and the city evolve over the time period of the case study? (2) What is the nature of “triage” – what practices are used to assemble coherent targets of intervention? (3) What kind of prostitute “body” emerges, both individual and aggregated and (4) *what are the ontological and ethical consequences*, what stories and possible future interventions are enabled or closed down by this assembling? In other words, *what are the ontopolitics of each site?*

The difficult questions to ask of my data, however, are the questions that “can balance on the cusp between the known and the unknown” (Rose, 2003, p. 149), questions that do not merely reiterate concerns in the field but which open up the work to a more speculative analytics, questions which deal with *how* we can know, not *what* there is to be known (*ibid*). It is my contention that knowing is informed by and in turn informs the production of difference and I look at the instrumentalisation, circulation, and resistance of differences as a mobile play of affect, pleasure, coercion and contingency at the clinics.

Structure of the thesis

In **chapter two** I present a genealogy and overview of the literatures that make up the theoretical approach underpinning this thesis. I begin by outlining my approach to biopolitics as it is actually practiced in contemporary Dakar: an approach which draws out affective pleasure over discipline; invisibilised and emotional labour over police work; and continuity over technoscientific novelty. I then think about the “emerging postmodern clinic” (Patton, 2011), what are the spatial concerns of these spaces which are shot through with different intervention strategies and different forms of expertise and which are so open to the city and to “global” science? Drawing on geographies of science I think about the management of therapeutic and non-therapeutic practice in clinical space, the constitution of “moral spaces” and the role of care and the affective economies of intervention. Finally I think about the ethical stakes in social and scientific practice in spaces marked by the traces of colonial sanitary regulation

In **chapter three** I flesh out the methodological approach in greater detail. I think here about historical ontology as method and about the complexities of subjectivity and the study of knowers and known throughout the thesis including difficult issues of empathy, identification, and feminist solidarity. Through an examination of my own positionality I think about my role as an ethnographer in the clinic, an ethnographer producing knowledge about (para)ethnographers – “my” method turned suddenly suspect.

In **chapter four** I think about the dysfunctional and partial nature of the regulation of “prostitution” as a policy riven with sexual and racial difference. I examine the particular contours and concerns of colonial regulation in Dakar. I then bring the analysis up to date, focusing on NGO workers struggling with the same problems as the colonial bureaucrats before them, that “most embarrassing question”: *who can be a “prostitute”?* The NGO workers approach to this is very different, however, mobilizing the “para-ethnographic” activities that Holmes and Marcus note are an increasingly “ubiquitous aspect of cultures of expertise (Holmes & Marcus, 2006). In the second half of this chapter I give a sense of the particular working culture of the NGO, the professional and personal worlds of the NGO-ethnographers which foregrounds the work of chapter five which examines their practices of knowing at work in the clinic. Here I interrogate accounts from the field which make “feeling” central to the knowledge project of NGO ethnography.

Chapter five tells the story of the Enda mobile clinic from its beginnings as a renegade intervention, to mainstream acceptance, to the messy conclusion in Dakar. I interrogate ideas about identification, ontological desires, and sexual difference to think about the ironic outcome of clinic work: the practices which constitute the women as “respectable” and recognizable subjects in gender are the very practices that the clinic staff use to identify them as “*clandestines*”. The body that emerges out of these knowing practices is the risky and unstable body of the *clandestine*. The very detailed account that the NGO-ethnographers are able to assemble makes all aspects of women’s lives, appearance, and embodiment, susceptible to being fused to the identity of *clandestine*. This chapter sees changing patterns of gender as an “outcome of the everyday actions of expressive individuals” (Pink, 2004, p. 12) and interprets the work done to classify and enumerate aspects of this gendered creativity.

Chapter six is a historical clinical ethnography of the Institute of Social Hygiene. I focus on the practices that drew experimentation into the clinical regulatory regime. I investigate enrolment and regimes of care at the clinic. I argue that the integration of an experimental regime does not just reflect the multiplication and thickening of historical ironies but that transgression between state bureaucracy, care, and experimental regimes create new bodies and new possibilities.

Chapter seven examines the (bio)ethics of regulation focusing on ethical and normative arguments around the “good” of experimental interventions. Following Vikki Bell I develop a feminist approach to ethical jeopardy and risk. I use Foucault’s technologies of the self to think about bioethics as an increasingly personalised and privatized set of practices in Dakar. I write a sort of “thick descriptive ethics” (Proctor, 1998, p. 11) focusing on how ethical behaviour which is conducted with the aim of handling and *attenuating* the potential harmful effects of difference, can, under certain conditions sharpen the salience of those differences and exacerbate asymmetries of power.

Origins of the research

In 2004-2005 I spent nine months in Dakar working for Enda santé. I was brought there by a UK university exchange programme – one of the strange quirks of privilege that sees many overeducated and under-informed young people dumped upon already harassed office staff in developing countries in the spurious pursuit of “cultural exchange”. It was the first time I had ever worked in an office and everything seemed richly strange. I began to observe the kinds of internal conflict that beset local community based NGOs such as Enda: the distinctions between field staff and office staff, and the articulation of that broiling resentment through savage humour. I learned the language of community development and also learned to parody it with the same sly satire as the other members of staff. I gained a small insight into some of the complexities, perversities and frustrations of trying to social justice work around an inflexible development remit. On the other hand I also frequently empathised with the frustrations of the donors and supervisors that programmes on the ground were slow to be rolled out.

This was an extremely exciting time to work with Enda as the mobile clinic project was just beginning. Everyone seemed slightly dizzy with the speed at which the organisation had managed

to move and flushed with success at having presented the clinic as a *fait accompli* to the city's authorities. I went out several times with the clinic and participated in meetings with the police and the donors where the exact purpose and short and long term goals of the project were defined. I began to think then that "regulation" (I was only dimly aware then of how it existed in its official form, and what I did know was filtered through Enda who tend to take a rather partial view) appeared to be a rather static set of practices and ideas; that is, they retained some of their shape and coherence as they were taken up and used by non-state actors. This observation was – and has pretty much remained – the core of my research agenda.

When I first arrived back in the field in late 2008 to begin my PhD fieldwork my intention was to develop this observation in an empirical exploration of the (dis)continuities of state and non-state regulation. At the time I thought that the empirical novelty of the case lay in the co-existence of these two overlapping forms of regulation: state and non-state; or, perhaps high modern and postmodern. I wanted to compare the experiences of women – what kinds of continuities could be traced across "sanitary regulation" and "non-governmental intervention"? Further I was intrigued about the NGO's internal differentiation of women's sexual behaviour. What happened when sex workers in Dakar got divided into *officielles* and *clandestines*? What were the material consequences of this classification? I reasoned that it should be possible to demonstrate that the women who resisted registration were then caught up in extra-local assemblages of power that "linked" them more directly to the bilateral funders of the mobile clinic programme than the other women selling sex in Dakar who sought protection and services from the state.

Beginnings

When I returned to Dakar I reconnected with Enda and began to attend staff training workshops and team strategy meetings, although these were now considerably less frequent than they had been as the team had grown, work had been "professionalized", and many members of staff now travelled for work documenting and working on other mobile clinic programmes. I also began to individually interview fieldworkers about their professional biographies, the history of the mobile clinic, and the changes and challenges they perceived in working around the clinic in the field.

While I drew together these interviews I also followed up on all contacts and leads I was given in the field. This ended up with me undertaking a short project of interviewing the head and field staff of *Projet Esther* – an “umbrella” NGO coordinating HIV/AIDS work which relied upon voluntary peer-educators and counselors drawn from the ranks of associations of PLHA and “stakeholders” including commercial sex workers. I was also introduced to a variety of actors including *Sida Service*, a Catholic organization providing testing and counseling services, and *Association AWA*, a sex-worker led organization that grew out of the state clinic.

I also conducted interviews with project managers and representatives from the ANCS – the *Alliance National Contre le Sida* – the NGO which controls the disbursement of the Global Fund in Senegal. Through this work I began to develop my understanding about the political and institutional context which created and managed the matrix within which different kinds of organisations were recognized and funded and how differently located professionals were “trained” and managed. This work and my deeply immersive experience in the language and culture of HIV/AIDS in Dakar have proved integral to writing-up the case study data.

The initial framing of the research project at Enda was articulated around an ethnographic history of the mobile clinic. I had reached this research objective because it was the research strategy which attracted the most interest and approval from people within the organization. The nature of this appeal has three main dimensions. People were attracted to ethnographic history in part because they found the idea genuinely interesting. They were also interested because a “history” appealed to an organization which constantly bemoans its lack of “institutional memory” and attributes a wide range of “failures” to this “data-gap”. Finally, this strategy also appealed because it was not a form of research that could easily replace or supplant the organization’s own research work which – as I will discuss further in Chapter Six – is considered a rather rarefied and pleasant activity: it is very gratifying to be singled out to conduct and write-up research reports. As Fisher (forthcoming, (Fisher, 2011) argues, the ideal of “collaboration” in research in which a Western researcher will “trade” research skills in exchange for access to certain experiences, does not always travel especially well and is often not intuitively understood. In particular, what might be an obvious and useful contribution to resources in an association or activist organization would be perceived as straightforwardly obnoxious in a professionalized NGO like Enda. Had I framed my

own project in terms of a research “contribution” I would have been perceived as someone who was coming to “steal” highly coveted office jobs.

In addition to this I found that informal oral history work – talking about the past and its relationship to the present – was a way of breaking up people’s “audit speech” – their idealized presentation of their work in which only problems which have been solved to everyone’s satisfaction are ever mentioned. Talking about a time when arrangements – for example, for care, or for the ethical conduct of research – were very different, allows interviewer and participant to build together some idea of the contingency of the present, the paths not taken, and the mess around the edges of practice. Talking about the past was also necessary in a culture where talking about the future or projecting any action forward into an always uncertain reality is extremely taboo. In these circumstances if we had not started talking about “the way things used to be”, all discussion would have taken place in an endlessly unfolding present tense.⁸

As I conducted this fieldwork around the mobile clinic project I continued to work with the Enda fieldworkers and to build up close relationships with them. I also became more proficient and confident in my spoken and written Wolof and developed a range of relationships that were supportive and helpful to the research process. In particular, I was drawn into local politics in Pikine via a friend at Enda who briefly sponsored a political party and was engaged in many different kinds of formal and informal community politics. However, at this point it would accurate to say that I was increasingly mired in “researcher fatigue” (Mandel, 2003). The tendentious and ill-informed commitments that I had made in my project design to “follow the network” and tracing connections across the city and between different institutional entities seemed more and more difficult to do.

It was at this point that I was referred by the head of Enda santé for an interview with one of the physicians at the Institute of Social Hygiene – as was typical in the field this was on the basis of a personal connection and a phone call made on my behalf. This moment also illustrates how little

⁸ This is one aspect of Senegalese bureaucratic culture that international bureaucracy and donor partners tend to find aggravating and obstructive. I have been in NGO training sessions where staff members have been instructed to “learn” to speak in a new mode following the formula: “In five years [I/the organisation] will be doing [this activity]”. They were each required to share an idea framed in this way and most of the group found the task challenging and emotional.

the “anthropologist hero” (Sontag, 1978) is the “sole author of [her] intentions” and breaks open the “role and effect of unacknowledged co-authors” in the research process (Reid-Henry, 2003, p. 194).

When I arrived at the Institute of Social Hygiene to begin work, I felt like my research had truly *begun*. The IHS is a very social space where many different people have their offices and where employees of the Ministry of Health mingle with the heads of large-scale NGO projects, orderlies and auxiliary nurses in a democratic and convivial atmosphere. People I knew from other parts of the city would inevitably drift through, on their way to keep appointments with civil servants and experts while patients waited to be seen. It was here, in the gracious grounds of the old colonial hospital that Dakar’s “HIV machine” seemed to be functioning most smoothly. At last, I thought, I’ve found my “village”. Lodged here at the heart of the old regulatory system, I would make the connections that would allow me to speak to everyone I needed to meet.

However, when I entered the STI-Dermatology clinic where the women are registered and consulted and began to observe the everyday practices of regulation – registration, consultation, testing, organized and ad hoc care – I realized that my first impression was distinctly inaccurate. Rather than representing a static, unbroken thread of regulatory practice conducted at this single site, enormous changes had taken place at the heart of the clinic; and if a pleasingly wide range of people had made their administrative home in this hospital, close to the “people” and the business of care, it was – at least in part – to access to considerable resources that these changes had brought.

Turning deliberately towards ethnographic history and a microhistorical approach was a direct result of my particular experience of visiting the state clinic and becoming slowly aware of the dynamic between the deep continuities of practice and the irruption of technoscientific resources and the resultant radical expansion in the horizon of bio-technological possibility associated with the arrival of the trial. These initial visits were the “event” (Clark, 2003) around which a series of methods and ideas coalesced. My experience at the IHS galvanized me into reinterpreting the mobile clinic data. Probing the different but interwoven cultures with shared the same clinical space at the Institute of Social Hygiene I began to see that all the spaces in which I circulated

produced “distinctive local regimes of managed sexuality” (Howell, 2010, p. 21). I became interested, then, in seeing how these local regimes overlapped with, worked through, or reproduced regulation, and what kinds of complex hybrids of practice had emerged when regulation was allied with experiment and with social development. In order to investigate this question empirically I adopted a micro-historical approach working up from specific, bounded institutions and tracing from these sites the network of connections – the mosaic of patched-together relations through which the “archipelago” (Bakker, 2003) of tricky and highly politicised health services are held together.

Conclusion

In this thesis I am dealing with the “contaminated triple historical heritage” of the scientific revolution, the Enlightenment, and transnational capital and technoscience (Haraway, 1997, p. 3) as these projects intersect with the desires of postcolonial actors. In this thesis I use ethnomethodology to remain attuned to the critical and plausible ways to change and democratise the practice of postcolonial technoscience through an understanding of the circular play of difference. Technoscience *uses* existing categories of difference in its process of “triage” but also refracts those differences and makes new embodiments *matter*; some of these matterings might, perhaps, offer alternative ways of conceptualizing and practicing science.

This does *not* mean escaping into a “grassroots postmodernism” (Esteva & Prakash, 1998), in which knowledge and abstractions are localised and carefully woven into “communities” – I directly examine the problems of such an approach in my discussion of bioethics in chapter seven. Rather it might mean investigating the “intimate” politics of “interventions”, a politics which builds upon Wendy Harcourt’s observation that the personal and embodied experiences of men and women are “at the core of what it means to live through what development imposes on people” (Harcourt, 2009 p. 5).

In my ethnographic work on the prescriptive work done by the micro tools of bureaucracy I focus on the point at which these tools “cut the network” (Strathern, 1996), enacting a finitude of association of the political, sexual and social. Henceforth these diverse and contradictory meanings are condensed in the body of a sex worker: *officielle* or *clandestine*. It is important to stress that this

is not (necessarily, always) a *reproach*. Engaging in high quality service delivery entails these kinds of research activities, mapping and representational work, and my desire is for women to have access to specialised health services. Being captured by bureaucratic and administrative tools is, for the marginalized, clearly often *preferable* to being ignored (Sheper-Hughes, 1992). However, in the work I have done in the field and in the writing up of this project I have found it compelling and urgent to trace the kinds of relationships and connections that bureaucracy has made, whilst arguing that there are always the *possibility of other connections*. The work of critique in this project then involves a constant interrogation of the conditions that have produced what is currently accepted as the “possible”, and the possibility of other conjunctures and connections producing different realities and different experimental futures. If a current knowledge assemblage can be assessed in this moment it is perhaps a question of the extent to which they “challenge the assumed naturalness of poor women’s ways of living and dying” (Haraway, 1997), and I return to this in the conclusion.

Avital Ronnell writes of the bodies “presumptively on drugs” which have been claimed by the state:

“Testing means, among other things, that your pee belongs to the state or to any institution or apparatus that thrives on the new civic readability. It is my duty to bring us back to the more original illegibility of your urine sample, or, at least, if I am unable to restore your pee to its proper place, to trace the contours of the complicated hegemony of testing” (Ronnell, 2003, p. 663).

I pursue the two strategies she offers in this thesis. First, I draw attention to irreducible complexities, lacunae in the dominant discourse, and impossible knowledges. Second, I look at the hegemony of testing by asking what kinds of embodied discourses have *permitted* the suspension of certain ethical relations and their replacement with (differentiating) regimes of testing, discipline, and classification.

CHAPTER TWO: THE SPACES IN-BETWEEN

In the previous introductory chapter I developed the central argument of this thesis: the practice and ideology of “sanitary regulation” has moved into new spaces and spheres and been taken up by new actors. These actors – experimental virologists and NGO urban health professionals – have both reformed and reproduced patterns of colonial-era sanitary governance, working across, against and through the basic technological and ethical tool kit of regulation. In this chapter I review the literatures that I have used to build the analysis in this thesis. My theoretical discussion here is focused around three themes: biopower and biopolitics; geographies of science; and the (bio)ethics of regulation. Running through each of these themes is a discussion of *difference*, that is, how difference is written into interventions and handled in practice.

Making difference: being feminist in STS

In mainstream public health literatures *difference* is often a weasel word – naturalising and reifying power asymmetries (Epstein, 2011). In contrast, feminist approaches to difference have attempted to “understand the discursive construction of “woman” across multiple modalities of difference” (Whatmore, 1998 p. 42). Questions of multiple and interlocking differences have pushed feminist theory “back” towards biology, reconnecting it strongly with science studies traditions of understanding the constitution of the material world, and challenging feminists to think with difference in new ways “without surrendering to either cultural or biological essentialism” (Kruse, 2010, p. 363). In this thesis I discuss the enactment of “prostitutes” out of the larger category of “women” through processes both *banal* and highly gendered: embodied interaction (talk about contemporary urban intimacies between fieldworker/ethnographers) and the registration of “self-identified prostitutes” at the Institute of Social Hygiene.

My interest in feminist theories of difference is refracted through cultural history and seeks to map the reproduction of the differences deemed salient and reproduced through the colonial sanitary regime in the knowledge practices of postcolonial science. That these highly sophisticated processes of gendered ‘triage’ determine access both to the goods of care and the ‘good’ of a

‘respectable’ or non-stigmatized gender and sexual identity, should remind us how *powerful* racial and sexual difference is today and how deeply it is implicated in the production of postcolonial knowledges.

Many scholars work at the point where older forms of biopower meet newer molecular forms. Paul Gilroy, for example, drew attention to how the “[r]ubble from the broken palace of bio-politics provided the foundations for what might be called “nanopolitics” (Gilroy, 1998 p. 845). Duana Fullwiley’s work on sickle cell anaemia exemplifies the empirical work into transgressions between older categories of race and new ‘molecular’ categories (Fullwiley, 2010). However, it is not accurate to say the “older” biopolitical categories are “simply” transposed into a new regime with no slippage or re-mattering on the part of the new actors who handle these categories in practice. Michael Montoya’s *Making the Mexican Diabetic* (Montoya, 2011), for example, draws attention to the purposeful work of the scientists in re-making “race” as a biological category through their forceful denials of socio-cultural aspects of their work that would query the integrity of the genomic categories they have determined and invalidate their projects.

I am also interested in who has the *power* to define difference and where that power might come from. Having differences recognised by technoscience might be an important step for lay actors who are involved in scientific research. For example, Steven Epstein examines how lay groups campaigned for new categories of difference to be integrated into research projects that were generalising treatment options from clinical trials that had drawn a narrow pool of subjects (Epstein, 2009). In chapters four and five I examine how the mobile clinic ethnographers produced categories that differentiate by weaving a fine skein of narratives about cultural practice.

Following M’Charek’s argument that “differences are not given ‘entities’ out there, awaiting discovery; rather they are effects that come about in relational practices” (M’charek, 2010, p. 308), I examine how the gendered difference of the “prostitute” is “made and unmade in sociotechnical practices” (Moser, 2006, p. 537). This analysis is spread over four empirical chapters and examines the historiography of regulation and the archive data; sexual difference and nomad subjectivities around the NGO mobile clinic; the “difference” a new (experimental) episteme makes at the

Institute of Social Hygiene; and the (non) accommodation of difference through bioethics. The principle differences that I examine are race, gender, and class; examining all the time how the three are implicated in each other's reproduction - so, for example, in chapter five it is distinctively *working class* femininities that are performed and iterated and made to mark the boundaries between "respectable women" and "clandestine prostitutes". However, I also think about the co-implication of *viral* difference (the women's unique viral profile), and geographical difference (the struggles of the scientists to establish some sovereignty over "their" women - a struggle which is complicated because of their location 'off the map' of global science).

Biopower and biopolitics

Within newer accounts of the politics of "life itself", the obsolescence of Foucault's paradigm of power is often attributed to Foucault's theory of biopower having been simply overtaken by the mutations in the "truth regimes of the life sciences" (Rose, 2006, p. 1). Flowing from scholarly interest in new scientific developments, notably the Human Genome Project which has captured the imaginations of many social scientists; scholars are investigating qualitatively new arrangements of biomedicine, technology, selves, and power: assemblages variously termed "biosociality" (Rabinow, 1999) and the "molecularisation of life" (Braun, 2007). Nikolas Rose argues that technologies that have enabled this molecularisation have rearranged political rationalities pertaining to the body, its individuality, its regulation, and its insertion into social life. He also argues - controversially - that this process has enabled an erasure of sovereign power in favour of "pervasive forms of pastoral power" (Rose, 2006: 7).

These theories about the rupture in the biopolitical governance of late modernity are taken to be constitutive of "what it means to live our humanity today", with the obvious caveat being that there is little analysis of the evolution of these processes outside of the global North. That this scholarly division of labour is taken for granted is interesting when we consider the powerful analyses that postcolonial scholars have produced arguing that the development and exercise of biopolitical power was *more experimental and more invasive* in colonial contexts than in the metropole (see Stoler, 1995). Kaushik Sunder Rajan argues that contemporary accounts of biopower are limited by their tendencies to see advanced liberal societies as the "normative forging ground of the biopolitical", and that there is little serious consideration in STS of the "biopolitical

elsewhere” except as conceptually derivable from the biopolitics of Western liberalism” (Sunder Rajan, 2011).

With a few exceptions – notably, Vinh-Kim Nguyen’s work on “therapeutic citizenship” (Nguyen, 2005) – few scholars have taken account of the fact that, as Roger Cooter memorably puts it: “the corporeal intersection of capitalism and consumerism [does not] cease at the biologised border of the bourgeois” (2007: 454). Questions dealing with the writing of shifting histories, the investigation of the ontological politics at the intersection of regulatory governance and technological change have been largely neglected. Where these questions do come into focus is in the cross-disciplinary literature which uses the work of Giorgio Agamben to draw the postcolonial “third world” subject as the limit figure to late modern Western techno-biopolitical possibility (see, for example, Minca, 2005), and the literature on the ‘experimental’ governance of clinical trials which I examine below.

My use of “biopower” in this thesis is influenced by three exemplary interventions: from an STS, an anthropological (and Africanist), and a feminist point of view. The first, an article by Raman and Tutton, suggests that there are key issues missing from work on the new horizons of the politics of life itself if we are to better understand “the cluster of multiple relationships that make up contemporary biopower” (Raman & Tutton, 2010, p. 713).

“.. if contemporary truth discourses about life contain a hybrid of molecular and population categories, it is no surprise that biopolitical interventions developed on this basis *are then too complex to support the claim that the old biopolitics from above has given way to a new biopolitics from below*. While we accept that the “great biopolitical strategy” of coercive eugenics is no longer a part of state intervention, there are still *normalized and more mundane population-based interventions*, led or coordinated by governments that represent important aspects of what we might call “state biopolitics” (Raman and Tutton, 2010, p.722, my emphasis).

Here Raman and Tutton stress that different forms of biopolitics (or, implicitly, forms of biopolitics that are enabled by different technologies) are dependent on each other and trade information between the two – working away at each other’s statistical assumptions. So, as Raman and Tutton point out: “visions of the population strongly influence the epistemic frameworks and design of molecular research, the enrolment of publics in research activities, and promises of their impact on clinical practice and health care (2010, p. 11). In this thesis I embed Rose’s claim that

“life is now understood, and acted upon, at the molecular level” (Rose, 2006, p. 12) at the Institute of Social Hygiene. Here, a network of sophisticated biomolecular laboratories are engaging in research work with women registered at the colonial hospital in the old “African” quarter – a quarantine zone.⁹ Clearly in the daily practice of biomedical research at these different sites, different sanitary ideas and regimes are bound together. Rather than a *transition* from one biopolitical regime to another – there are overlapping and co-existing discourses, practices and possibilities. If we can “detect[ing] and critique[ing] the different scales and spaces in which populations are conceived and governed” (Legg, 2005, p. 144), we may renew the theoretical vocabulary of biopower as it is practiced at *molecular* and *municipal* scales (Poleykett, forthcoming, 2012). In other words it is not enough to merely cite the “biopolitical” – it is necessary to empirically consider the relationships between *historically constituted fields of biopolitical power*, and “newer” and emerging fields of biopolitical calculation, and to consider the *material effects* that these overlapping regimes have upon the women who inhabit the spaces in-between them.

Didier Fassin (2009) in an important intervention into contemporary deployments of biopower, and one which has been very influential on this thesis, argues that the play between countervailing forms of power has been overstated in contemporary accounts of biopower. According to Fassin the “stakes” [enjeux] of governing are equally important in Foucault’s original conception. Fassin’s reading brings *meaning and values* to play in the analytics of biopower, concentrating on the extent to which individual regimes attach legitimacy to (certain forms) of life and living, a process which he calls the “imposition of biolegitimacy” (Fassin, 2009, p. 44). Fassin is skeptical about the utility of a politics of “*life itself*”, instead preferring to think of “*life as such*”, a form of biopower which centers experiences of suffering and related moral principles which are not captured by governmentality-oriented subjects of biomedicine. I follow these insights closely in this thesis, focusing on the biopolitical work that ethical reasoning does in classifying and making matter groups of women and the role of difference in this work. I also follow Fassin’s lead in this chapter by discussing at some length the shift from a “bioethics” to a feminist “ethics of the body” centered on an examination of *enjeux*.

⁹ See Raymond Bett’s analysis of the construction of the Medina as a quarantine zone for “native” Africans following an outbreak of bubonic plague in Dakar in 1914 (Betts, 1971).

These questions of value and legitimacy coupled with the recognition that colonial-era biopolitics has left indelible traces in contemporary arrangements leads me to a particular feminist imagining of intimate biopower which is also integral to this thesis. This take on the literature addresses the particular structuring regimes of value in which human worth is adjudicated and bodies are “made killable” through structures of difference (Haraway, 2008, p. 80). However, these insights also led me towards the creation of value through (feminized labour). Fortunati identifies women’s biopolitical labour as the “creation of value that must appear otherwise” (1995: 8, cited in Skeggs, 2010) The “politics of life *as such*” is central to the fieldworkers’ feminized “biopolitical labour” as they struggle to develop and maintain trusting working relationships under difficult working conditions. Their biopolitical labour is also discernable in their shaping of professional identities around their ability to classify and attribute sexual and social characteristics to particular forms of dress, embodiment, gait and appearance. Fieldworkers must struggle to have this labour *recognized* and to translate it into a different and more transferable kind of capital.

These three re-imaginings of biopower – *spatial, ethical, and affective* – make up my approach to the politics of “life itself”. In this chapter under the rubric of geographies of science I think about mixed clinical sites where “old” and “new” biopolitical forms are interwoven – questioning Raman and Tutton’s rather blithe assumption that the “great biopolitical strategy of coercive eugenics” has entirely disappeared. Following Fassin’s re-imagining of biopower as the politics of “life *as such*” I place ethical calculation at the heart of my analysis and interpret it as fundamental to struggles for material resources and power. I pay particular attention to how changes are “ethicised” and legitimated through practices generated in these overlapping biopolitical orders. In chapter seven I develop an extended argument about the *productive role* played by bioethics – that truth regime which is supposed to protect human selves and bodies from harm – in the elaboration and exploration of ideas about what a body is and what a body can do, ideas which are fundamental to the exercise of biopolitical power. Finally I use writings on gendered biopolitical labour to think about the accumulation of value from invisibilized labour. This focus brings to light in – I hope – a very sympathetic way, the “emotional labour” (Hochschild, 1983) undertaken by those who make interventions work and who often receive little financial reward for their work.

Care, power and the affective economies of intervention

The point at which emotional labour connects to biopolitical orders in contemporary theory is perhaps best illustrated through a brief discussion of the turn towards care. One of the key aspects of my case studies – a very simple one and almost impossible for anyone pursuing an ethnomethodological approach to ignore – is the importance of care in establishing relationships. These relationships, however, are not in themselves neutral and these “warm” and “friendly” interactions are often cited by registered women or by users of the mobile clinic services as the *reason* that they engage with the clinics and that they return there for their care. “Caring” gives beleaguered and poorly supported workers a sense of moral purpose, but it is also a sticky and awkward practice that does more than anything else to entangle women into relationships that often impose certain burdens upon them. This very straightforward observation has been largely ignored in the “experimentality” ethnographies (the particular sub-genre of anthropological work on experimental practice which I examine below). This work tends to focus on care as a key commodity characterized by its presence or absence in clinical spaces.

In contrast I am interested in what the “turn” towards care reveals to us about a new *politics* of care. Care is a longstanding theoretical concern of my own. I began my research career at Masters level with more “traditional” political-economic accounts of caring while researching gender privilege in care giving practices and gendered meanings that cluster round private/public and masculine/feminine axes. I saw for myself the slippery, anarchic practice of care – the way in which caring for another with a different embodiment (or, indeed, caring for a “cognitively impaired” individual – older women suffering from dementia), forced people to re-evaluate things previously invisible to them: the easy intimacy of a marriage, people’s cultural assumptions about old age, the built environment through which they had moved so easily and unthinkingly before they assumed caring responsibilities. At the time it was sometimes frustrating for me – carefully attuned to the buried gendered meaning in their discourses – to listen to these stories about washing the curtains and re-hanging them, about vacuuming and preparing meals. My research participants located care in an accumulation of mundane tasks and a series of re-alignments of their own worlds that they had undertaken in order to provide “good care” for their dependent partners. This is the kind of expanded and inclusive definition of care that Mol, Moser and Pols (2010) propose when they write that “[c]aring practices.. include technologies: from thermometers and oxygen masks to

laboratory tests and video cameras. *If they happen to be helpful then they are all welcome*” (Mol, Moser, & Pols, 2010, p. 14).

I am also concerned with how the “goods” of science can be translated into culturally meaningful “care” for the communities who are enrolled in scientific work. In chapter six I use non-normative ideas of care to argue that care exists in *trial-work*, the banal practices of data gathering and research, that the test is perceived and experienced as “caring”. In other words, in this particular instance, the (material) “goods” of the trial, is the (ethical) “good” of the clinic – it doesn’t need to be manipulated, translated or otherwise transformed to make it “caring”. It seems critical to me, when constructing accounts of trials that critique their use of care as incentive, to interrogate and unpack the work of care in the clinic in an ethnographic and collaborative fashion as it produces quirky pieces of data that tug against the “experimentality” narratives which tend to remain unconvinced that “caring” is *possible* in a context of material inequality and exploitation. Throughout this thesis I think reflexively about care and caring as a theoretical means of shifting the dominant emphasis on the mitigation of harms into new and more political registers. In other words I think about the *intimacy* of care as a *dispositif* (Oswin & Olund, 2010) and how affective relationships might impact on knowledge outcomes and thus shape power relations. That is, rather than seeing warm and caring friendly relationships in the field as gratifying or as a potential mitigation of any harmful power effects that might be generated in the intervention, this analysis plunges into the play of affect in micro-incidents of research and intervention practice. This approach draws on the literature on affect which privilege analogue rather than digital modes of power and community, or “connected and relational over oppositional modes [of power]” (Hemmings, 2005 p. 550).

Feminist social scientists working with care are committed to exposing the role of care relations in reproducing relationships of inequality. As McEwan and Goodman argue, in this literature “social relations produced through emotion and emotional connection are also understood as sites of power” (McEwan and Goodman, 2010, p. 110). In Chapter Six in particular I think reflexively about my own (inappropriate) *longing* for a care I would find culturally intelligible, ‘warm’ and gratifying. Hannah Brown urges that anthropologists learn to empathetically collaborate in the process of defining and contesting “good care” (Brown, 2010) – a quantity which can vary across

differently located institutions. Starting from the point of assessing what care *actually looks like*, the affective registers in which it is implanted and from which it is interpreted, allows me to think with culturally specific forms such as ‘roughhousing’ humour and the playful take on age-hierarchies at the Institute of Social Hygiene as a *kind of care*. However, these forms of care are always understood as political and not merely as a kind of sociality with which to lubricate the awkwardness and pain of registration. Rather, being cared for the clinic is a key factor in the creation and contouring of the experimental cohort and therefore must be *implicated* in the social reproduction of the experimental regime at the site.

Geographies of Science

In this thesis I follow the disciplinary intersection where the strong tradition within STS of writing ethnographies of “these strange places called laboratories” (Latour, 1983: 141) intersects with geographers’ projects to formulate space and place as basic and not as epiphenomenal or subordinate. The laboratory ethnographies attempted to expose the contingent, located, and partial nature of scientific knowledge – focusing on how the sciences are “made”, cooked up in laboratory spaces which have their own intellectual and material histories (Latour & Woolgar, 1986). However, geographers of science are increasingly concerned that researchers in the sociology of science frequently evoke spatial metaphors without necessarily engaging with or using spatial theory. As Beth Greenhough argues in this work space is seen only as a “means of *visualising* and *critiquing* the social history of scientific objectivity”, mobilizing a flat and “functional sense of science’s relationship to space” (Greenhough, 2006b, p. 225). There is an increasing awareness of the distinctive contribution that spatial theory can make to science studies (for an overview, see Powell, 2007) building on the insight not simply that science is done in spaces and therefore has a geography but that “science itself creates spaces and places for its own activities and in turn spatializes the world in a wide variety of ways” (Naylor, 2005, p. 3).

Blended sites

Shapin and Schaffer in their classic case study in the historical geography of science argued that the experimental method evolved in close relationship with the creation of the laboratory, “the space so clearly bounded that dispute could safely occur within [it]” (Shapin & Schaffer, 1985, p. 303). Arranged in this carefully designed space were reliable or “modest” witnesses who reported

what happened in the laboratory in a dispassionate or ‘scientific’ manner, the “authorized ventriloquist[s] for the object world” (Haraway, 1997, p. 24).

However, in modern science the “cultural glass wall” between the field and the laboratory (Kohler, 2002, p. xiii) has increasingly been broken down. Szerszynski (2005) argues that the laboratory has shifted from a site of *fabrication* (focused on the construction of models that can then be dismantled or transported), to a site of *action*: “[r]ather than creating durable objects on the basis of a pre-existing model or idea, they rely on the human capacity to ‘act’, to create radically new elements, organisms or life processes. The boundlessness of action consists not only in its ceaselessness – the fact that, unlike fabrication, it has no natural endpoint – but also in the *self multiplication of its consequences*” (Szerszynski, 2005, p. 187). Studies of science and society examine the laboratory as a “moment in a series of displacements that makes a complete shambles out of the inside/outside and the macro/micro dichotomies” (Latour, 1983, p. 168). In this thesis the laboratory is located as a particular place which must both *produce and consume* knowledge about the wider city in which it is embedded. Laboratory experiments are “simplificatory devices: they seek to tame the many erratically changing variables that exist in the wild world, keeping some stable and simply excluding others from the argument” (Law & Mol, 2002, p. 2). The laboratory must also *manage* the “clinical hinterland” (Polekett, forthcoming, 2012) of care that surrounds the experimental space, and this is an ethical, political, and epistemological struggle which – as I explore in chapter six – is engaged by “street level bureaucrats” (Lipsky, 1980), both those who are trained in and attached to technoscientific production and those on the fringes of its function. I am interested in the cultural and epistemic geographies of experimentation which focus on how experimental practices “circulate through and extend into *putatively nonscientific zones*. What I am interested in here might include recent research by geographers on the “unseemly affinities between experimental matters of fact, biopolitical modes of rationality, and historically specific forms of governance” (Powell & Vasudevan, 2007).

Moral Spaces

Geographies of science have also focused on the political textures of laboratory landscapes – the rules, implicit and explicit, governing access to these privileged spaces.¹⁰ The particular contours of this privilege, the distribution of expertise and exclusion, are specific to the local politics of place that attach to particular laboratory sites. As well as having a *politics* the spaces of clinical intervention and scientific research that I study are also, I argue, *moral spaces*: spaces where the acquisition of moral knowledge is explicitly foregrounded, and spaces where moral and ethical errors can take place and also can be managed and overcome.

In chapter seven I focus on how laboratories are perceived as spaces in which one acquires basic knowledge about “good” and “bad” conduct in the context of trial work. In Dakar, I argue, proximity to the “centres of calculation” (Latour, 1987: 215) not only guarantees the “power to reason” (Hillier and Penn, 1991), they also grant people the power to make ethical calculations, to mobilize ethical knowledge and to practice ethics “correctly”. To use ANT language, this understanding of bioethics has led to the laboratories functioning as “obligatory points of passage” (Latour, 1988, pp. 43-39). In this way, I make my own argument about the artificiality of the distinction between field and lab. Gieryn, for example, argues that “[f]ield scientists often immerse themselves in a site for long periods of time, developing embodied ways of feeling, seeing, and understanding – that become analogues to the cold precise instruments of the lab” (Gieryn, 2006, p. 7). I think about the development of protocols as the embodied, experiential process of “feeling, seeing, and understanding” the *lab-as-field*, analogous to Latour’s understanding of “acquiring a nose” (Latour, 2004a). Applying a human geography sensibility to these imaginations of place and the meanings that can stick there can throw up fascinating beliefs about the laboratory as a “moral space” (Ploszajska, 1994; Whitehead, 2003) not simply a space of moral and ethical reflection/calculation – but a space in which people are *exposed* to moral danger, through which they develop ethical selves.

“Global” science and postcolonial science studies

In chapter seven I examine the scaling of those spaces in which people become moral agents. This moral negotiation and problematisation is partly stimulated by the clinic’s place in a “global”

¹⁰ Donna Haraway comments on this in her review of Shapin and Schaffer’s work, noting their silence on “the structuring and meaning of the specific civil engineering of the modest witness” (1997: 26).

science project, a place which must be defined and defended by Senegalese scientists attempting to preserve the autonomy and primacy of Professor Mboup's Senegalese-led team. These dilemmas are related to the very great asymmetries of power in these relationships and how these asymmetries might map on to economic and social geographies, questions which speak to the emerging interdisciplinary paradigm of postcolonial studies of technoscience.

There is currently a growing interest in exploring postcolonial histories of science and technology that tell stories that query and decentre scientific "exceptionalism" - the belief that Western science is the only human knowledge system "capable of grasping reality in its own terms" - that these alone have the resources to escape the human tendency to project onto nature cultural assumptions, fears, and desires" (Harding, 2009 p. 301); and scientific "triumphalism" the belief that the spectacular failure of technoscience to contribute to the improvement of the life chances of the world's poorest is *external* to that science and belongs to "politics" (Harding, 2009) - a view which, as I expose in chapter seven, is not shared by postcolonial scientists (Anderson, 2002; McNeil, 2005).

It appears to me that this postcolonial project is an urgent one in the context of African studies. As Gabrielle Hecht observes, work which focuses on Africa and "globalisation" has tended to overlook the "technological so frequently invoked (by non-Africanists) as material channels for global power in the contemporary world." (Hecht, 2010, p. 214). However, questions of power, difference, and the partial and insufficient critique of science's exclusionary knowledge base has become more live and more difficult as STS scholars have begun to work on the production and experience of science and technology in non-Western contexts. We may "all" be "citizens of Technopolis" - that country not represented on any map (Winner, 1988: ix); but the conditions of citizenship to this technological space are distributed in a radically uneven fashion. Much of the more self-consciously "celebratory" techno-feminist accounts of women and technology seems problematic when transposed into contexts where access to, ownership over, and "literacy" in science and technology is limited to a small and privileged percentage of the population. Undoubtedly it is urgent, in postcolonial contexts, to locate technology in wider historical and cultural patterns of power. "The hard truth" as Cockburn argues, is that technoscientific

innovations “are applied in a world in the grip of a third millennium militarist, masculinist and imperialist project.” (Cockburn, 2004).

What can postcolonial theory contribute to STS, and how might that entail an “interrogating and retooling of STS analytics that we have been using for studies of laboratory practices” (Prasad, 2008: 36). If we do not engage in this “retooling”, Prasad argues, we risk becoming entangled in deeply problematic complicities. This “re-tooling” and the need to build science studies theories that are sensitive to difference is a problematic I engage across the whole of this thesis and to which I return in the concluding chapter.

Experimentality: ethnographies of clinical trials in the majority world

However, one of the critical points at which these scattered questions of power, space, place, and “global science” *does* currently come together is the contemporary ethnography of the clinical trial. This work is based in the scattered archipelago of experimental sites situated around at sites around the world which meet some key criteria: some *biological distinctiveness* in the population, quiescent government structures prepared to welcome scientific experimentation and an adequate bureaucracy upon which trial-work can draw in order to constitute experimental populations.

Adriana Petryna who first coined the term ‘experimentality’ worked first on clinics in the Chernobyl zone and subsequently more generally on the anthropological problematics of travelling trials. Vinh-Kim Nguyen has worked on the trial as a key regulatory structure standing at a scale between citizen and (absent) state, citing for example his involvement in Cote d’Ivoire in creating identifying papers for trial participants who had not received the same official recognition from their government (Nguyen, 2010). Others have focused on the social meanings of membership in trial work (Fairhead & Leach, 2011) or the “kinship like ethics” that arise out of long term involvement in biomedical research work (Geissler, 2008). In a different context, Roberto Abadie has worked on the “professional guinea pigs”, North American anarchists who make money “guineapigging”, an activity which allows them to limit their engagement with the mainstream economy while at the same time participating at a particular juncture of capital-labour relations that represents one of the most egregious example of the limits placed on choices that people make for and with their bodies under liberal capitalism (Abadie, 2010).

In this thesis, however, I want to respond to and explore a growing interest in how geographies of experimental practice can be theorised beyond the institutionalisation and emplacement of scientific knowledge and beyond stories of predatory capitalist exploitation carving experimental populations out of cultures made vulnerable by poverty or environmental disaster. I want to think myself beyond some of the ways in which I have ‘done’ the historical geographies of sanitary regulation in my doctoral work, and towards some complexities; the non-linear aspects of experimental histories; the discontinuities and the paths not taken, the quirky, fleeting and ephemeral moments of experimental life and the affective textures of collaboration in “global” science. However, I want to do this whilst continuing to pay attention to what is my central preoccupation as a feminist researcher at this site: the continual inscription and reproduction of difference along axes of race, gender, class and location in the asymmetrical cartographies of “global” science. Thinking about the stories that fall outside of the narrative of the “epistemic emplacement” of the research regime in the clinic, I will try to think about how these stories suggest alternate spatialisations of the body of the research participant, and the material effects of the uncertainty of experimental life as it is lived on what Reid-Henry calls the “epistemic periphery” (Reid-Henry, 2010).

The (bio)ethics of regulation

What should be clear from the above is that I do not find the meta-narrative of “experimentality” convincing. I do not believe that the people I work with are entirely caught up in the implacable machinations of an experimental regime. Neither, however, do I think that they work under conditions of their own choosing – and I pay close attention to the efforts they make to protect themselves from different kinds of risk to which they are exposed through the proximity the experiment. Historicising, localizing and nuancing “experimentality” does not necessarily entail compromising or blunting the political tools available to intervene upon experimental regimes. Might we begin to nuance accounts of “experimentality” with stories about citizen patients moving between overlapping fields of historically constituted instrumentality, inhabiting and exploring different identities in each one? What kinds of agency might become visible in these moments and at these junctures? Having one’s body (or knowledge of one’s body) *instrumentalised* or used for the

potential benefit of a third party is a risk for “others” who have only recently had their bodily autonomy and their right to make decisions governing their body legally recognised.

Feminists have been particularly keen to explore technoscientific processes which mine humans for the biomedical or cultural “goods” as it is clear that if biological goods can be bought and sold that this market is developing in the context of a *highly unequal economy of bodies*. It is undoubtedly true that these transnational processes are creating complex constellations of ethical practice. However, as Greenhough and Roe (2006) argue: “... the positionality of diverse citizens vis-à-vis the global biotechnology industry has been an object of concern.. but such discussions often focus on the conflict between society’s right to scientific research and people’s right to ownership of or control over their own bodies or a nation’s right to natural resources” (417). Bioethical debate often comes down to a decision about *whose* rights will take priority and a definition of the conditions under which *normally* sacrosanct principles of bodily autonomy can be suspended. Not only is there, as Greenhough and Roe argue, little space for addressing how people are making sense of possibilities posed by biotechnological innovation, there is even less space for interpreting – in a generous and constructive manner – the means engaged by “street level bureaucrats” and ordinary scientists to handle ethical jeopardy.

However, although bodily commodification and instrumentalisation seems to run counter to long-standing feminist concerns about promoting women’s right to make decisions defining their bodily autonomy and integrity, it is also from feminist theory that a series of critiques of the normative humanist underpinnings of these processes has emerged. For example, Cussins (1996) uses ethnographic data gathered at a fertility clinic to “question the humanist argument that selves need to be protected from technological objectification to ensure their agency and authenticity” (575). “Objectification”, she argues, is only antithetical to personhood in specific circumstances that can be “traced and understood” (*ibid*). In chapter six I pursue a similar argument when I discuss the “fragmentation” of women’s bodily proxies and their dispersal around the laboratory as a particular kind of “warm” and positive experience through which women’s value and the attention paid to their care is affirmed by the proximity of the laboratory.

Haraway argues that instrumental relations are not in themselves the problem as ‘to be in relation

of use to each other is not the definition of unfreedom and violation' (2008, p.74). This starting point immediately represents a *departure* from the key assumptions of mainstream bioethics: the assumption that the "body is a unified entity separate from those who seek to govern its activity" (Diprose, 1994, p. 7). Moving away from these accepted truths of bioethical practice we must begin to consider *other* questions, such as "if we have to use, how do we use responsibly and ethically?" (Crist, 2010, p. 642).

The study of ethics and ethical decision making has been central to the anthropologically informed ethnographies of science that have been published over the last decade. Michael Fischer argues that ethnographies of science should focus attention on striving to capture the "dramaturgically rich spaces of repeated, and recursive, tournaments of ethical decision making" (Fischer, 2007 p. 564). I study these operations in detail in chapter seven when I think about how the subject who cares for others comes into being in the highly unequal and problematic ethical terrain of the Institute of Social Hygiene. Here I am interested in how "caring" subjects are crafted and I draw on Foucault's later "positive conception of ethics", a conception which includes "the consideration of practices, selves, bodies, and desires that determine (and are codetermined) by ethics" (Colebrook, 1998 p. 50 cited in Mahmood, 2005 p. 27). Rather than drawing on Kantian form of ethics which pays close attention to the application of the *critical faculty* of reasoning to ethical problems, this conception "allows us to think of ethics as always local and particular, pertaining to a specific set of procedures, techniques and discourses through which highly specific ethical-moral subjects come to be formed" (Mahmood, 2005, p. 28). Rather than seeing a necessary conflict between habit and the exercise of moral reasoning, Foucault sees ethics as a *modality of power* that "permits individuals to effect by their own means or with the help of others, a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being" (Foucault, 1988, p. 17).

Conclusion

In this chapter I have signaled my interest in the interpenetration of "old" and "new" biopolitical regimes at the clinical sites I study. How are technoscientific techniques implicated in the reproduction of the biopolitical status quo? Beginning from two clinical case studies I am also

interested in the spatial concerns of the “emerging postmodern clinic” (Patton, 2011, p. xv). When regulated bodies are brought into contact with technoscience, in what spaces, through what social relations, and in what clinical arrangements do they take place, and how are those spaces in turn constituted by scientific practice?

Second, this thesis addresses questions of care and the affective economies of “intervention”. I ethnographically consider the experience of urban health workers in Dakar in an attempt to parse some of the distinctive experiential and moral dimensions of working these systems. What are the moral requirements of the work that these professionals perform to keep these soft infrastructures moving (Kleinman, 1999)? Not only do I think about the precarious professionalism of people who work in care, I also think about the implication of the subjective, the warm, and the “caring” in the relations of power that underlie sociality at the clinics, a *politics of affect* (Ducey, 2007; Thrift, 2004). A final set of questions which this thesis seeks to explore relate to the ethical undertaking of science, regulation, and the heterogeneous forms of practice that lie somewhere between the two. I explore these issues under the rubric of the (bio)ethics of regulation. The question “*what can a body do?*” is used as a motivation to explore some of the “humanist” principles that seek to protect bodies from the harm of instrumentalisation and which underpin “bioethics” – a supposedly universal discourse governing contentious practice in an increasingly wide-ranging set of bio-technologically enabled environments. Here I also develop an extended discussion of how humanism inheres in critical science studies through an examination of the literature on “experimentality”. I conclude with a discussion of a key concept which profoundly informs this thesis and which – it seems to me – can illuminate the moral and ethical dilemmas of extending technoscience into clinical arrangements of care and regulation: the contemporary “turn to care”, the interdisciplinary project which seeks to build non-normative stories about care which might result in a more “carefull world” (McEwan & Goodman, 2010).

What has remained unarticulated in this chapter is the process by which the “prostitute” subjects are constituted. In the next chapter I will think about the ontologies of regulation – how the diverse regulatory practices I have examined actively *enact* a “prostitute” subject and how the deep affective connections between knowers and known help to constitute that subject. In the following chapter I also think about how relationships are constituted across the mixed spaces of care,

regulation and technoscience and I lay out the methodology I used, a “multi-layered ethnography focused on the emergence or ontology of things perceived as ‘epistemic’”, focusing on the ‘problem’ of “constituting the objects of evidence at the same time as constituting the criteria for objective knowledge” (Cooter, 2007, p. 458).

CHAPTER THREE: THINKING THE SUBJECT: METHODOLOGIES, AUTO-ETHNOGRAPHIES, AND ONTO-EPISTEMOLOGIES

Sitting in Dr Thiam's immaculate living room, I have switched off the tape recorder, Mamadou has wandered in, and we are talking about the history of the mobile clinic. Dr Thiam dwells on the *skill* of the fieldworkers in drawing out the women, gaining their confidence to the point at which they can begin to form a picture of their lives. Mamadou returns the compliment graciously, commenting on how much the women like Dr Thiam. The doctor says that he has learned a lot by asking questions, that he has caught echoes in their biographies of stories that shocked him with their *ordinariness*. "You know", he says thoughtfully "after hearing those things you understood why they thought that prostitution was the only possible option left for them". Visibly moved he speaks of a woman who heads up a group in a respectable inner-city suburb "*a beautiful woman with children in the last year of school*". She leads a double life – respectable mother to her four children and prostitute; once you have had this woman in front of you in a consultation, he says, you can see then that "*l'individu est compliqué*". He speaks of the preconceived ideas that he had, all of the bureaucratic stories that make up the "*prostituée clandestine*" and then the women that he meets and their own stories. He makes a simple gesture with his hands weighing the two and then bringing them together: "*l'individu est compliqué*". - Fieldnote, July 2010.

This thesis is a history of an evolving, institutionally produced subjectivity – and a case study in the technical creation – through apparatuses of classification, biomedicine, lab work, social work, and care – of an intimate identity amenable to the complex knowledge projects of colonial and post-colonial technoscience. Methodologically, therefore, I am concerned with studying accounts of *knowing* and I use various methodological means to examine knowing practices. I am studying the ethnomethods of variously located actors – the experiential and formalized means that fieldworkers use to acquire, practice, and instrumentalise knowledges about commercial sexuality in Dakar. Rather than studying the discursive "construction" of the "prostitute" through texts, conversation, and formal interviews, I have tried wherever possible to rely upon non-participant observation and ad-hoc interviewing in order to study the "enactment" of the prostitute. In other words, this thesis is studying the *ontological politics* (Mol, 1999) of the clinics, spaces which I have argued are constituted of blended therapeutic, experimental, and regulatory regimes of practice: fields with their own strategies, materialities, and ontologies. Developing Braidotti's insight that "the formation and emergence of new social subjects is always a collective enterprise, "external" to

the individual self while also mobilizing the self's in-depth and singular structure" (Braidotti, 2011 p. 18), I study the emergence of particular kinds of knowing and caring selves, and how those selves produce novel objects of intervention/regulation.

In all the different cultures of knowledge production that I study there is one aspect which I find particularly interesting: the processes through which the subject-regulator comes into being and *acquires* a position from which to pronounce upon the object of regulation/intervention. This subject comes into being through the strategies of "professionalization" which I examine closely in the following chapter, but also through acquiring sympathetic knowledge of the (regulated) other. This analysis prefigures the focus of chapter seven which deals with "self-writing" in ethical caring relationships, but is worth mentioning here because this is a process saturated with transformative - and powerful - affect. This affect is also relational, articulated through technologies and materials locally available at the clinics (such as testing, which I examine as care in chapter six), and also through interactions with *myself*.

In this chapter I deal with my own field experiences, my own positionality, and my own status as a knowing subject trying to tell truthful and responsible stories about regulation and regulators. It seems to me very important to expose some of the vulnerability and the "cultural and academic guilt" (Punch, 2011) with which I struggled in the field. I have chosen to do this not to *excuse* or explain any gaps or insufficiencies in the research; rather I am acutely aware that in talking and thinking about emotional labour and ethical jeopardy in the personal and professional lives of my research participants I shine a light upon their emotions and intimate desires. It seems appropriate, then, to expose the kinds of pressures that I came under in the field and how I tried to hold together *my own* professional and personal identity in the face of different kinds of risk, and to use this intimate data as "grist for the ethnographic mill" (Stacey, 1988, p. 23). Probyn (2010) suggests that we must engage in a careful exploration of how we research the intimate "if we are to be equal to the feelings of those we are engaged with" (Probyn, 2010, p. 2). Rather than wanting to "crowd out" the voices of research participants with the "introspective self-indulgence" (Keith, 1992, p. 556) of my own emotional accounts, I follow Despret (2004) who argues that "[t]o 'de-passion' knowledge does not give us a more objective world, it just gives us a world 'without

us'; and therefore, without 'them'... in other words, a poorly articulated (and poorly articulating) world" (Despret, 2004, p. 131).

In the first chapter I mentioned some key clinical ethnographies that had influenced my work and my methodological approach. The main difference between my own work and those works cited, however, is that most of those ethnographies take "subjectivity" as the key conceptual means of following the entanglement of individuals in institutional histories. In Eric Silla's study of leprosy in Mali, for example, identity is seen as an "artifact" of interaction between individual and society (Silla, 1998 p. 28), he approaches the "physical transformation of one's body and the related transformation of one's identity" as "historical events", working through biographical data to understand how people "acquired identities rooted in leprosy" (p. 1).

My approach in this thesis is different. Firstly I do not speak *directly* to the "beneficiaries" of intervention/experimentation, and I give my reasons for not placing this data at the heart of the project this below. In this I am following recent and experimental ethnographic work which breaks out of the realist mode and problematizes work built along a continuum of governmentality-subjectification-resistance. Kaushik Sunder Rajan in conversation with Michael Fischer on methodological approaches to studying participants in biomedical trials in India argues that it is possible to study a distributed *experimental subjectivity*: "experimental subjectivity is not just a real condition of life but is also an epistemological construction – constructed simultaneously by biomedicine, bioethics, law and regimes of value and capital" (Sunder Rajan, 2010). He is arguing that subjectivity is not merely experiential; it is enacted through discourse and also in highly specific interactions and highly specific places. In this thesis I am more concerned with the persistent contouring of the conditions of possibility for women in the city – the ontopolitics of the spaces of knowledge production about changing practices of commercial sexuality than I am with individual women's experiences. I want to find out how new regimes of practice construct women as part of a social body in ways which differ from (or, alternatively, resemble) the classic liberal biopolitics of sanitary regulation. In particular I am fascinated by blended spaces, clinics that insinuate themselves into existing institutional structures, clinics which mix different logics into a hopeless ontological mess, and the *political consequences* of that endless mixing.

However, no ethnographer – and perhaps even more so no feminist ethnographer, however committed she is to uncovering and exposing the work of categorization and analysis, however absorbed in the lifeworld of experts, however intrigued by the stories that humanitarian police work tells about itself – can ignore the suffering body. Whilst I do not necessarily enter into speculation about the subjectifying work of new and complex formations of power, I do listen to the women and their stories about their struggles for health and I re-tell some of those stories here. Equally, it is impossible to engage with the worlds of the “regulators” without recognizing the complexity of their tasks and the efforts that they make on behalf of the women and without developing close affectionate relationships with many of them and I make no apology for the understanding I extend to the “regulating classes”.

Defining the field: writing clinical culture

In the introductory chapter I discussed the origins of the project. Here I now enter into more detail about the methodological approach taken at each site. Feierman and Janzen (1992) suggest that research into health and healing in Africa should be carried out in the “most intimate spheres of people’s everyday lives and overarching political and economic power” (cited in Silla, 1998 p. 29). This thesis focuses on a particular kind of *institutional intimacy* – the intimacy of the clinics. In order to do this work I draw upon Probyn’s account of “researching intimate spaces” (Probyn, 2010); traditions in African history and ethnography of writing clinical spaces (Kilroy-Marac, 2010; Sadowsky, 1999; Vaughn, 1983); and the clinic as a trope in feminist accounts of biopower and women’s gendered experience of biomedicine.

For women the clinic has often been a space charged with both “eugenic and liberatory potential” (Rapp, 2000 p. 3) and this tension is a theme that I trace throughout this thesis. The clinic is a space of care but also a space to which access is often distributed in uneven or problematic ways. I follow many others here in drawing attention in this thesis to the extraordinary mobility of blood and tissue samples across clinical landscapes and national borders, and contrasting that with the struggles that women often face locally to get the referrals and the care that they need. The clinic is a highly variegated space shot through with power relations and spaces of clinical secrecy and risky disclosure. The clinic is the forum in which patient-physician (and, in the case of the clinics I study – a whole range of other actors) is played out, and it is here where “a set of social, cultural,

structural and asymmetrical relations intertwine" (Fortin, 2008). Even considering the micro-interaction of patient and physician stripped of all its socio-cultural determinants, this is a highly complex moment which has attracted much attention in the sociology and anthropology of medicine. For the physician, the clinic is a space in which they must acquire – and practice – a certain moral knowledge: as Kleinmann and Benson warn, "[f]inding out what matters most to another person is not a technical skill. It is an *elective affinity to the patient*. This orientation becomes part of the practitioners sense of self." (Kleinman & Benson, 2006).

This thesis is in close dialogue with *The Birth of the Clinic* (Foucault, 1973). Published after *Discipline and Punish*, many interpret the text's excavation of medical perception in light of the former's insights on the disciplining of bodies, or instead group it with Foucault's study of governmentality. Others, however, have argued that this complex text contains within it quite distinctive insights which receive greater attention and more elaboration in the later volumes of the "History of Sexuality" (Patton, 2011; Philo, 2000). I do not share all of Foucault's fascination with visualisation as a key modality of power: my analysis tends to focus far more strongly on socialities and care, a response to the cultural context in which I work. Nor do I confine my analysis to the evolution of medicine, and I tend not to treat the "doctor-patient relationship" (which Foucault describes, wonderfully, as being described within the "feebly eroticised vocabulary of 'encounter'") as an important unit of analysis. The doors of the clinics I study are thrown open to an extraordinary range of volunteers, peer-educators, empowerment specialists, ethnographers, and social workers. The doctors themselves, in their multiple encounters with unrepentant prostitutes, moral scientists, and bureaucrats, have gone far beyond simple "doctoring". Contemporary African clinics are spaces where a great range of experts and different forms of expertise jostle for recognition and I people my clinical ethnography with these characters. I also supplement Foucault's theory with work from feminist cultural history and studies of technoscience, thinking carefully about technologies of gender. I draw upon Deleuzian and affective literatures placing an analytical accent on desire and pleasure rather than discipline and resistance. For me the crucial critical question is how certain desires: for care, conviviality, and for the *pleasure* of having one's social and sexual identity recognized within the parameters of normal or non-pathological then tie into asymmetrical relationships of dominance and appropriation.

The clinic is a key node in biopolitical regimes as it stands between the “general population” and those who are selected through differentiating processes of triage for care or discipline. Thus clinic space is often considered “apart”, a legal and ethical black hole, but it must also import knowledge from its outside and export its own knowledge out into different kinds of practice. Clinics tend to be spaces in which there are deep continuities of practice, but they also have their practice working upon and re-organised by changes in the way in which biomedicine is understood and embodied; or by new ethical challenges to business as usual. As (Halberstam & Livingston, 1995) observe, Foucault’s argument is that a shift in power/knowledge was effected in the eighteenth century when doctor’s stopped asking their patients: “What is the matter with you?” and began to ask “Where does it hurt?”; they add a third salient question: “what is happening to your body?” What is *happening* to the bodies: individual and “social” in the clinical encounters that I study?

The Institute of Social Hygiene

At the Institute of Social Hygiene I use three main methods. The first methodology was detailed and lengthy oral history interviews with each of the two the trial doctors who had been “implanted” by the research regime and whose salaries were initially paid by the Natural History project. In these interviews we discussed the histories of the discovery of HIV-2, the setting up of the cohort trial and the difficult back-and-forth of defining and contouring the priorities of the research project. The trial doctors were vital informants at the Institute of Social Hygiene because they were responsible for mediating between the research project and the clinic, for juggling scientific work and biomedical care, and they developed a set of strategies for doing this which I discuss in chapter five. Obviously I could not observe any of the clinical interactions between the women and the trial doctors but we discussed in broad terms the kinds of problems that the women would bring to the doctors, and the kinds of solutions the doctors would suggest. I was able to talk informally to the women registered at the clinic and to observe how warm and mutually respectful their relationships with the doctors appeared to be.

The second methodology was participant observation of the daily “stuff” of clinic work. I sat with the two social workers in the central office and observed the bureaucratic work. This involved registering new women, dealing with problems such as lost cards, and generally attempting to resolve the health and personal issues of the women who presented themselves at the clinic. My

presence on the social/care side of the clinic was accepted to the extent that I was able to conduct *ad hoc* interviews with the staff nurses, the *sages femmes*, and the head nurse, asking questions as they arose. However, I also recorded more formal interviews with the social workers, explaining that I was interested both in the history of the trial and in the contemporary functioning of the clinic. For these interviews I spoke Wolof or French depending on the seniority, level of education, or preference of the staff member to whom I was speaking.

The third methodology was a “following” of the circulation of data extracted from the women registered at the Institute of Social Hygiene. This involved both tracing the circulation of blood samples from the clinic to the Laboratory at Dantec, and also a careful reading the scientific archive: the abstracted version of aggregated and analysed changes in the cohort over the period of the Natural History Study. This helped to expose the “articulation between different sites” (Casper & Berg, 1995, p. 400), the forms of practice that weave together disparate places – while, at the same time, producing the distinctiveness of that place – such as Mme Faye’s impatient and slightly disingenuous comment to me at the Institute of Social Hygiene: “tout ce qui est biologique c’est à l’hôpital le Dantec et avec le Professeur Mboup”.

The Enda mobile clinic

The mobile clinic is not strictly a *site* – work around the clinic took me to many different parts of Dakar and eventually to Mbour a small seaside town a couple of hours from Dakar for some comparative work. It could equally have taken me to Guinea Bissau and Cape Verde where there are decentralised mobile clinic programmes, undoubtedly doing very distinctive and fascinating work. Mapping the connections between these ethnographic sites was fascinating. However, there is a particular register of experience which I attempt to convey in chapter five, the juxtaposition of the shining and well-equipped mobile clinic and the highly impoverished places where the sex workers live and work, which can only be experienced by accompanying clinic staff on consultations.

I went out with the mobile clinic, often following the clinic on the back of an informant’s motorbike, by taxi, or by public transport. While the clinic is parked around the corner as discreetly as possible, the *animateur* organises *causeries*, or general training/ undirected

conversations, usually hosted at the house at the “group leader”, or the woman who has drawn the group together out of her own social circle and some local networking. I was introduced to the women as a *gestukat* (researcher, although there is a pleasing semantic ambivalence, it is often taken to mean *someone who is searching for something*), asked to give my name and a brief introduction in Wolof, teased, and then, usually, forgotten about. These *causeries* are the basic unit of the Enda intervention, the women are given basic biological information, safer sex advice and condom negotiation techniques while they wait to be consulted by the mobile clinic (the clinic is often the “draw”). I observed the basic stuff of social work: listening to problems, checking women’s prescriptions, finding somewhere for them to be consulted if they need further medical attention. There are many other moments that make up the encounter with and around the clinic – moments when the women capture the interaction complain vociferously to the *animateur* that their “turn” to get more investment, microcredit, more help, has not yet come. Moments when they draw the *animateur* to one side to ask a question; moments when the male members of the household wander into the room, are repelled, and withdraw. The observation work greatly enhanced my understanding and was necessary in order to draw out some of the everyday work which “disappears” into practice and which is very difficult to access and capture using interview data. Ethnographic work at each space also allowed me to experience some of the specificity and strangeness and to experience some of the sense of place at each site.

Back at the office I sat with people as they worked. We photographed and analysed together the *rapport de terrain*, translating the tricky and subtle process of social work into a field of input/output data. This strategy of the impromptu interview built around these task “props” was particularly successful with the Enda social workers, with whom I have a warm and close working relationship. At both the Institute of Social Hygiene and the mobile clinic my interview data, whether unplanned and impromptu or formal and recorded, often involved asking questions which were initially puzzlingly obtuse, questions about process, order, and tasks, rather than perspective, experience and meaning.

Defining the subject: talking and not talking to sex workers

“It is awfully important to know what is and what is not your business” – Gertrude Stein

As I have briefly explored in chapter one it took me a while in developing this project to see that the affective textures of caring relationships and people’s experiences of those relationships were utterly integral to thinking about the workings of the two clinics. Perhaps this is because prostitutes’ experiences have been a mainstay of women’s and gender history since histories of sexuality were “discovered” in the 1980s. The study of women involved in different commercial sexual economies has often been accomplished in the spirit of E.P Thompson’s stated aim to “rescue the poor stockinger [and] the obsolete handloom weaver from the enormous condescension of posterity” (Thompson, [1968] 1980 p. 12). I had initially loosely planned on a phase of research which would focus on the experiences of sex workers at the mobile clinic and **at** the state clinic, although I had always committed to investigate other possibilities. I decided fairly early on in the research process not to focus on sex worker experiences, even as my Wolof improved to the point at which I could interact independently with the women in these two settings. Making the decision not to include sex workers’ experiences in my project is significant and requires a full and careful explanation – I also expand on this decision in the empirical chapters as I go on to explain the nature of my interactions with sex workers at each site.

My reasons for not placing sex workers’ experiences at the heart of my project were primarily ethical. My own capacity for critique would have been attenuated had I focused on how consent and ethics are shaped by the deep history of the Institute of Social Hygiene, for example, and yet used the access that I had negotiated and been granted by doctors and professionals to formally interview sex workers. However, it is not accurate to say that I did not speak to sex workers. In situations when I was observing their interactions with clinicians and professionals it would have been inconsistent with my ethical obligations, not to say highly discourteous in this extremely garrulous society *not* to talk to them and not to explain the reason for my presence. Some of the thoughts that they shared with me are in this text although many are not.

I spoke to women selling sex outside the mobile clinic as they waited for their prescriptions; I spoke to them in the Institute of Social Hygiene as they waited, sometimes for many hours, for

their appointment; I spoke to them as they waited for the documents that confirmed the date and place of their birth, their right to sell sex, their sero-negative status. Everywhere that these women went they waited. I believe that I never spoke to any woman who was unhappy to speak to me and I answered any questions they had about me or about my research as honestly as I could. We conducted these conversations in French, Wolof, and the peculiarly hybridised version of the two that uneducated Dakarois speak. Because I didn't work with research assistants, whichever AIDS professional was guiding me at that moment was my mediator, helping with translation and clarification and locating that woman's experiences within the network of relationships that governed her access to health services. Sometimes this relationship worked wonderfully well, sometimes less so, observing and being a part of this interaction was always fascinating. Nothing changes the fact that I had no right to speak to these women or even to acknowledge that I was aware that they were selling sex without the presence of a third party and outside of the context of the regulatory system which was my object of study. Certainly it was difficult for me in conversation with sex workers to position myself away from the relationships which provided the context of our conversation but this difficulty was salutatory, it reminded me of my own privileged position, European, the recipient of a certain training with which I purchased my entry into elite NGO circles; my researching self was inextricably bound up with these asymmetries of power. Undoubtedly the women would have told me different things if I were a different researcher, if I had encountered them in a different place, if I had worked closer to them, found a way of building deeper relationships and winning their confidence. I have no way of knowing what they would have said under these circumstances, and it would be irresponsible to speculate. I did not try to follow single women and trace the thread of their story, although I was of course much closer to some than to others and those women are far more present in the text. In pursuing these dysfunctional narrative methods, I was inspired by Sommer's approach:

'Refusing to deliver the women to the reader in a linear, tidy narrative, we intended to block and displace easy identification and sentimentalising empathy. Thus the text works toward constructing a respectful distance between the reader and the subject of the research, producing a kind of gap between the text and reader that is about inaccessible

alterity, a lesson in modesty and respect, somewhere outside of the ‘murderous mutuality’ presumed by empathy’ (Sommer, 1994: 157, cited in Lather, 2002).

As Vincaine Despret argues: Empathy may be transformative, but that transformation is of a limited and a solipsistic kind: “Certainly, empathy transforms the subject (the one who feels empathy) but this transformation is a very local one as long as it does not really give his object the chance to be activated as subject, the subject feeling empathy remaining the only subject of the whole thing. While pretending to be inhabited (or locally transformed) by the other, the empathic in fact ‘squats’ in the other. Empathy allows us to talk about what it is to be (like) the other, but does not raise the question ‘what it is to be “with” the other’. *Empathy is more like ‘filling up one self than taking into account the attunement.’*” (Despret, 2004, p. 128). Certainly in the history of feminist work many feminists have developed a ‘wounded attachment’ with the figure of the “Third World Prostitute” (Doezema, 2001). Vicki Bell writes that this *ressentiment* based in feminine suffering “relies upon a negative stance that only says ‘no’; its only creative deed is to refuse” (Bell, 2000, p. 61). Building relationships with “regulators” – relationships which are full of empathy but also relationships which encounter moments at which empathy stutters and fails, moments of divergence and stubborn rebellion on my part, some of which I explore in this chapter – involves difficult and involved work of attunement.

In contrast “prostitutes” experiences in my text remain piecemeal, inaccessible fragmented, ‘non narrativisable’ (Spivak, 1988: 284), belonging only to the moment that I encountered them, at a precise juncture in the complex itineraries of their entanglement with the state and with the NGOs. The analysis of our encounters, therefore, necessitates an evocation of the place where the encounter took place and its spatial coordinates within broader more or less institutionalised networks as much as what was said. I take these coordinates as the markers of the specificity of research moments, and not the *stories* of individual sex workers; their biographical particulars, their modes of selling sex (the most common typology), and their complex, conflicted and deeply private understandings of their own sexuality.

None of this is to say that interviewing sex workers at both clinics would not yield compelling data about the “coming into being of an urban subject .. suspended between complex negotiations of

community, market and state within the life world of the urban poor" (Das, 2003, p. 97). However, this thesis argues that it is *equally* important to study the people who are often excluded in health research when beneficiaries are prioritised. Many of the people who I work with at the clinic are women doing highly feminised labour such gynaecological exams and taking blood samples. This work is straightforward from a technical point of view but which also requires great sensitivity and some HIV pre- and post-test counselling awareness.

Karen Booth points out in *Local Women, Global Science* that "[nurses] are predominantly female the world over. They are also among the workers most directly and intimately involved in tying women's bodies, particularly those of working class and poor women, to state institutions and state control. It falls mainly to middle class African women who have been trained in medicine for anywhere from two to six years to bring scientific knowledge and health technology to bear on the treatment and counseling of Kenyan women" (Booth, 2004, p. 6). Not only are these women (and some men) key actors in the kinds of social, medical and scientific processes that I am exploring, they are also "do so much of the work involved in bringing the science, policy and technology of HIV/AIDS to people at risk in Africa and delivering most of the data we have about heterosexual AIDS have been rendered invisible by the design, conduct and publication of that research" (7). There is, then, a clear feminist agenda in "making visible" the work that these women do, work that is not represented in the "official" archive of scientific representation.

Moreover, as Lock and Nguyen argue, the relationships and understandings of health workers are instrumental in making change happen: "It is the cultures of organisation, of biomedicine, and of other powerful actors that are more often pertinent factors in shaping the outcome of public health initiatives than are the values embedded in targeted populations; yet such cultures of power and intervention are studied only rarely" (Lock & Nguyen, 2010, p. 10). This research gives access to *new* knowing subjects, subjects that come into being and find their voices amplified at the intersection of shifting geopolitical processes. The knowing subjects in this thesis are not those who voices are usually heard: the "man-white-western-male-adult-reasonable-heterosexual-living-in-towns-speaking a standard language" subjects (Deleuze, 1987, cited in Braidotti, 2011, p. 198)

While I hope it is clear that I recognize and indeed dedicate this thesis to a large extent to the work and professionalism of these individuals labouring to make systems work, I also chose to work with the professionals whose stories I tell here because they are located at a particular and peculiar juncture vis-à-vis the state and also in relation to their “stakeholders”: women selling sex. They occupy a tenuous role in a boundary profession. Their attempts to *create* an object of regulation/intervention is about needing and wanting to find a distinct subject for whom they can speak and not (necessarily) some grotesque and overweening will to power. They can do this by evoking the cultural authority of science (Johnson-McGrath, 1995), or by evoking qualities that are *innate* to their selves and to their professionalism, and I explore this latter tactic at length in the following chapter.

Throughout this thesis I want to argue that investigating the world of the ‘regulators’ does not mean breaking faith with the ‘regulated’; the women who transact with the clinic for legality and some limited freedom of movement in the city. Rather, I hope that telling these stories about the vagaries of experimental life might begin to open up a greater understanding of the axes of differentiation across which bodies are classified and made to matter between the city, the clinic and the laboratory, and the always-ambivalent ethico-onto-political entanglements that ensue.

Positionality and difference

My relationships with the research physicians, the NGO researchers, and the social workers at the IHS certainly fulfill the criteria of empathy and mutuality that Oakley identifies as crucial to feminist research (Oakley, 1981). However, as Judith Stacey writes, this mutuality is in itself problematic because these participants occupy positions of *relative* privilege compared to the sex workers. Researchers are increasingly focusing on the “ubiquity” of emotional work in research (Bondi, 2005) and the ways in which emotions “form a rich moral array through which the world is thought and which can sense difference things even though they cannot always be named” (Thrift, 2004). This builds on the contention that feminisms can only move beyond “the impasse of indifference” (Probyn, 1993) by simultaneously articulating questions of ‘who am I?’ with those of ‘who is she?’ (Whatmore, 1998, p. 44). I therefore want to consider some questions of my positionality in the field and its influence on this thesis.

In the calibration of elements at the clinic that shape the local and fleeting subjectivities I trace in this thesis my presence undoubtedly plays an important role. As a European I am for almost everyone in the clinic a person who might potentially offer influence, cash, some small part of a longer strategy whose significance the actors themselves have not yet quite unraveled. One woman, an *ancienne* at the Institute of Social Hygiene, and I struck up a friendship and I was frequently inveigled into giving her small sums of money. She knew inside-out how to capitalize on my curiosity. For example, she once proposed that I invest in a small business venture of hers, she would buy ingredients and prepare and cook sandwiches in her *quartier*, then she would tell me about “*naka leen tudd? Ay resultats*” (what are they called? The *results*) and (in return) I could write about it in my “book” (*yaa dinga ko bind ci sa teere*) assessing the relative success of small-scale investment for commercial sex workers. Interactions of this kind speak volumes about registered women’s savvy when it comes to interacting with ‘outsiders’, and their sophisticated grasp of what a researcher might find interesting. Similarly, the head social worker at the Institute of Social Hygiene Mme Faye would often invite me to attend long and exhausting days at her community-based organization as the presence of a European marks certain credibility, showing that the organization is networked to larger structures.

Comments made to me by sex workers stressing the usefulness of Association AWA (that I should support) can be interpreted in light of the influence I was often mistakenly thought to have. I interpret these comments, in particular in chapter seven, as one strand of a fractured subjectivity – a *local* subjectivity formed through the traumatic process of enrolment and initiation into being a “sex worker”, and through the knowledge that a “virtuous” and compliant performance at the clinic will ensure better relations, better care, and potentially investment in the form of microcredit channeled through Association AWA. In other words, I thematise my own difference and locate interactions within a negotiation of that difference.

In my experience the frictions, embarrassments and the frequent unpleasure of research is ultimately what produces some of the most powerful analysis. Sarah Moser argues that personality and ‘emotional intelligence’ should be included in the run-down of individual positioning in the field (Moser, 2008), an article that I read with a sharp stab of dismay as my whole life has been a struggle with shyness. My introverted tendencies can pass now unnoticed in most cases in my own

culture but are thrown into sharp relief by the easy practice of social interaction that most Senegalese cultivate to the point of an art form. However, this experience and this positioning allowed me to see what was so singular and important about *care* and *being a good fieldworker* to people's sense of professionalism. A dissonance which asserted itself in interpersonal interactions helped me to finally see the investments that people had made in "human relationships".

If I have tried to move past the "impasse of in-difference", while not staging an empathetic relation (one that is all *difference*, a distancing stance which underlines passivity) in the text, there is still the question of the difference that my own writing makes. Throughout this text I am handling the idea of the "prostitute" as I discuss how her body has been materialized in particular space-times. In order to do this I must reflect on my disciplinary position – on the edge of anthropology by dint of co-opting its method – and the history of this discipline to the production of cultural difference:

"As a professional discourse that elaborates on the meaning of culture in order to account for, explain, and understand cultural difference, anthropology ends up also constructing, producing, and maintaining difference" ... "anthropology needs others that are different from the self" (Abu-Lughod, 1993, pp. 12-13).

Where cultural differences have been difficult to negotiate in the field I have tried to foreground these moments in writing practice – as a sort of *memento* to avoid fetishizing difference. For example, in chapter six I explore my ambivalence about the care that I was witnessing in relation to my desire for a different and idealized kind of care.

Ethnomethods and the fieldworkers: ta[l]king care of bodies

In this thesis I am concerned with and have drawn attention to a neglected set of marginal professional identities and I wish to demonstrate the centrality of these new forms of expertise in the city at key junctures of state neglect and neoliberal restructuring. However I am not only investigating these identities for their intrinsic interest; I am interested in *what people do* to make regulation/intervention "work", the "persistent effortfulness that makes a 'present'" (Spivak, 1993 p. 156 cited in Lather, 2004). Drawing on approaches in geographies of science and trying to build a picture of the "clinical hinterland" of the diverse knowledges and archives that the two clinics produce, I focus on the "local, banal, ephemeral, mundane, material practices" which are implicated in the "very constitution and performance of spaces" (Kraftl, 2009). In order to do this

I chose to pay close attention to the ethnomethods of fieldworkers and experimental virologists – and to study the work of their self-directed, reflexive activity. An ethnomethodological approach aims to capture *both* the experiences and biographies of these individuals, their reasoning and reflection about their work, and an observation of the effects of the actions of these particular individuals. Oral history work with people employed at the clinic brings to the fore the kinds of problems that arise when accommodations must be made to new ways of doing things. Casper and Berg in their (1995) article, one of the first to acknowledge the impact of biotechnology on “banal” medical sites such as the clinic, noted that:

“Blurring artificial distinctions, between the social and non-social aspects of medical work, health workers are constantly trying to control all these elements – but their control is never complete; it keeps slipping away through the continually appearing cracks in the articulations made earlier” (Casper & Berg, 1995, p. 402).

Ethnomethodology as articulated by Garfinkel (1967) has long been considered a curiosity in contemporary social science (Laurier & Philo, 2004), a product, perhaps, of the social sciences’ preference for grand theoretical debates over the “fine analysis of procedures invented by actors” (Callon, Lascoumes, & Barthe, 2009 p. 165). However, like microhistory, it is enjoying a resurgence of popularity – in particular among theorists of affect and practitioners of Non-Representational Theory (see Loughenbury, 2009). Ethnomethodology allows a way in to “common-or-garden spatial phenomena and talk-in-interaction” (Laurier and Philo, 2004: 422). I would also add that it allows attention to be paid to the affective textures of care and interaction, as Sharad Chari argues “subtle movements of affect, of stance, tone and bodily comportment” are equally as important as *talk* to the “workings of power and knowledge, and to the illuminate of daily struggles over the course of social change” (Chari, 2003, p. 171). In chapters four and five in particular I think interactions between fieldworkers and “prostitutes” as a meeting and mingling of affects producing pleasure in knowing and recognition and as the ethnographic fieldwork encounter as a “composition” of affects (Deleuze & Guattari, 2008, p. 284). Methodological questions over how to “model the psychic and sensory apparatuses that afford specific kinds of embodied knowing” (Blackman & Venn, 2010) are open and live questions. Here I explore them

as in a particular and circumscribed way examining the intersection of knowing and care with recognizable and culturally specific socialities.

Ethnomethodology insists that seemingly objective social facts and objects such as the “market” and “bureaucracy” should be studied as *accomplishments of interaction* (Zimmerman, 1978). This intersects with the aim of microhistory to get as close as possible to the scale at which change happens. This was also the underlying methodological justification of the laboratory ethnographies. As Latour writes:

“Take some small business owner hesitatingly going after a few market shares, some conqueror trembling with fever, some poor scientist tinkering in his lab, a lonely engineer piecing together a few more or less favourable relations of force, some stuttering and fearful politicians; turn the critics loose on them and what do you get? Capitalism, imperialism, science, technology, domination. In the first scenario, the actors were trembling; in the second, they are not. The actors in the first scenario could be defeated; in the second, they no longer can. In the first scenario, the actors were still quite close to the modest work of fragile and modifiable mediations; now they are purified, and they are all equally formidable.” (Latour, 2003 cited in Thrift, Driver, & Livingstone, 1995, p. 1).

All the way through the research that this thesis presents there are moments that are difficult to reconcile with larger narratives of exploitation and expropriation of bodily goods by power-hungry scientists. The citizen-scientists at the state laboratory in chapter six may be mobilizing the cultural power of “technoscience”, but they struggle all the time to assert their own objectives, to imprint their own idea and ideals on a “global” science project. The NGO-ethnographers may market their skills to “read” the embodiment of (in most cases) their fellow working class women, but they are underpaid and overstretched and gambling on NGO work turning up the right resources that might allow them to provide more comfortably for their families in highly uncertain financial situations.

Conclusion: Making-up “prostitutes”: historical ontology as method

I am not only interested in ethnomethodology for these ways in which it grounds the practice of technoscience and ethnography in particular institutional cultures. My approach to ethnomethodology also incorporates a material-semiotic analysis drawn from feminist technoscience studies (Haraway, 1992) and is influenced by the fundamental understanding of Actor Network Theory, that “entities take their form and acquire their attributes as a result of their relations with other entities” (Latour, 1999: 3).

The purpose of my investigation into my research participants’ practices and interactions with different kinds of tools and technologies (including ethnography) is to expose how “facts, objects, realities, and social orders are made to be, how they emerge and are sustained, their materialities and how they literally come to matter” (Moser, 2006, p. 542) and, in turn, to examine the ontopolitical effects of these practices (Mol, 1999). In this thesis I take regulation to be a socio-technical undertaking mobilizing particular knowledges which are constitutive of new orders in the city. My methodological approach privileges the exploration of how “realities emerge in and are effects of relations” and including in that inquiry “practices, materials, and orders other than those of texts and discourses” (Moser, 2006, p. 542).

Feminist cultural studies of science have forcefully drawn attention “to the ways in which the discursive and material aspects of sociotechnical relations and processes of materialisation are inextricably intertwined” (Asberg and Lykke, 2010: 299) building a scholarship in which “gender politics are not simply about the relationships of men and women but are focused precisely on how to understand agency, body, rationality, and the boundaries between nature and culture” (*ibid*, 2010). Using ethnomethodological methods I study individuals working in postcolonial clinics, on the edge of overlapping, complex and often almost incommensurate expertise, inhabiting unstable professional identities. Working alongside these individuals I look at the ways in which they “attune to, interact, and shape” objects in practice (Mol, 2002, p. i). Rather than studying the discursive “construction” of the “prostitute” through text, conversation, and formal interviews; I am studying the “enactment” of the prostitute and for this I am relying principally on participant observation. I am interested in the multiple ways in which the object of knowledge is *actively constructed* in interaction. I am interested as well in how these interactions bring into being

“prostitutes” using the infrastructures of the sciences (as well as borrowing promiscuously from whatever kinds of knowledge are at hand).

In contrast to constructivist approaches which assume that the “real” of the material world is filtered and refracted through a situated knower, becoming in the process saturated with subjectivity, “hard” or what Puig de la Bellacasa simply calls “feminist constructivism” challenges this “optic order” by requiring “a more subtle thinking of the ‘agency’ involved in knowing, yet without necessarily speaking for immediacy, for directness in touching the real, or nature” (Puig de la Bellacasa, 2009, p. 309). Where constructivism left “singular, intangible, untouched” the *object* of a plurality of gazes, post-constructivism seeks to track the multiplicity of the object, not just in the past but in the present (Mol, 1999 p. 76).

However, when we begin to apply the insights of this work to messy, human practice, and to conduct work from a feminist perspective – it becomes very clear that (1) there is a *politics* to knowledge practice, a politics that Annemarie Mol terms “ontopolitics” (1999); and (2) not all actors are equally placed to create and enact realities (Star, 1991). Worlds are materialized in some forms rather than others (Haraway, 1994) and as Janelle Taylor puts it: “to inquire into the ordering of materializing practice is to ask how, *in the same movement that bodies are enacted, relations of power are forged*” (Taylor, 2005, p. 746). Paraphrasing Mol the question then becomes, who is regulated? Where are the options? And what is at stake?

CHAPTER FOUR : COLONIAL BUREAUCRATS AND NGO ETHNOGRAPHERS: TWO RESPONSES TO THE “WOMAN NAMING CRISIS”

In the first half of the nineteenth century “prostitution challenged anatomical analysis because prostitutes were so difficult to count” (Poovey, 1995, p. 89). In this chapter I begin to flesh out the “story” of regulation and how the regulators respond to that “*most embarrassing question*”: who can be a prostitute? First I present some of the historiography of regulation and the data from the archives in Dakar showing how colonial authorities in the city adapted to the challenges of regulating urban women, both “French” and “native”. The second half of the chapter is dedicated to the analysis of the professional culture of NGO. In contrasting these two groups: colonial bureaucrats and NGO-ethnographers, and the methods they use to “know” prostitutes – one group operating at the beginning of the last century and another exemplary of the knowledge strategies at its very end – I hope to show some of the continuities and also great differences in the professional cultures and research strategies of the “regulators”.

This chapter is also concerned with introducing key themes of emotion, affect, and caring labour and I feel that this is an area in which my work begins to make a novel contribution to African studies. There have been ethnographic examinations of the ethnomethodologies of “street level” workers from the point of view political economy which have focused on “grounded” accounts of bureaucrats and their role in making institutions function (Blundo & Le Meur, 2009; Roitman, 2005). These works have focused on “people’s crafty and idiosyncratic ways of finessing persistent problems” (Crang, 2005), and on elucidating and explaining the local rationalities that govern behavior within institutions and which might, for example, block the imposition of different behaviours from the outside. Equally, work on the caring professions in Africa: nursing, counseling and doctoring, have expanded the repertoire of study to include “emotional labour” (Booth, 2005; Brown, 2010). Much of this work, however, has failed to explicitly connect emotional labour and affective investments in the political economy of care in the city and this is gap that I seek to redress in this thesis. I would like to focus not only on the material stakes that differently located employees hold in various bureaucratic outcomes, but on the close and intimate relationships that staff build up with the women whose lives they research and seek to intervene

upon. The work I do in this chapter towards explaining how integral and instrumental these relationships are to the successful accomplishment of different goals at both clinics lays the foundations for my later analysis in the empirical chapters showing how slippery and uncomfortable a quality “warm” relations of care can be in the peculiar social worlds of the clinic.

Regulating Prostitution

The “regulation” of commercial intimacy is a generic term for the role that the state takes in defining and policing the sale of sex.¹¹ However, regulation also takes place in the street, in brothels, in private houses, and on an ad-hoc basis, for example, when bar owners tolerate or eject certain women. Feminists have long thought with “regulation” as a means of thinking through the sites at which authorities “establish the subjectivities that endanger the nation and [those] that promote citizenship” (Andrijasevic, 2009).

The strategies that a state can adopt to legally define prostitution and to control and sanction its practice are usually classified as abolition, prohibition and regulation (Outshoorn, 2004). Abolitionist countries such as France adopt the position that prostitution should be banned and all third parties criminalised. Interventions focus on trying to prevent or discourage women from entering prostitution and helping them to exit the milieu (Mazur, 2004). In contrast, the US is a formally prohibitionist country, although they are spaces where the sex industry is recognised and functions autonomously. Regulation, whilst it has a specific historical meaning which I will expand upon below, has come to function as an ‘overall term denoting state interventions in the running of prostitution’ (Outshoorn, 2004, p. 8). Within these three broad rubrics many different positions can be accommodated and each legal posture may be differently framed and inflected within different political cultures between states or within states between institutions or municipalities.

The diversity of regulatory strategies reflects some of the complexity of legally defining commercial sexual practices. Firstly, sex is by no means a stable or self evident commodity. In Japan, for example, only the sale of penetrative vaginal sex is criminalised and all other forms of commercial

¹¹ In the following chapter I justify the inclusion of a non-state intervention – the Enda mobile clinic – under the rubric of “regulation” by examining the ways in which the state has deliberately and tactically ceded control of the *clandestines* to the NGO.

sexuality are legal. In the UK there is considerable debate around the legal status of the sale of sexualised ‘entertainment’ such as lapdancing (Agustin, 2005). Secondly, female commercial sex work is a site where debates over claims of citizenship, individual rights, bodily autonomy and the acceptable limits of state intervention in the intimate sexual lives of its citizens are focused and refracted, and the particular flavour of these debates varies substantially across different political cultures. Finally, differently located governments define the object of their intervention into commercial sex work differently and thus engage different agencies in the pursuit of these goals. Governments broadly regulate sex work in order to maintain law and order, uphold standards of public morality and protect women from violence, abuse and risks to their health. However these priorities are ranked differently in terms of national priorities and this priority setting determines ‘in which political area and policy (sub)system the politics of prostitution (are) fought, which actors (are) able to get in or (are) excluded, and what interest groups form around the issue’ (Outshoorn, 2004: 6). Different interest groups, for example, feminists and labour rights activists, frame the ‘problem’ of prostitution in very different ways, produce different critiques and offer different solutions.

It is possible to further nuance legal models of prohibition, regulation and abolition by considering how different legal systems define who can inhabit the identity ‘prostitute’. In the UK for example, moves have very recently been made to remove the legal identity ‘common prostitute’ from the statute books on the grounds that it is pejorative and unjust. ‘Common prostitute’ was a status assigned to women if they had been cautioned for ‘loitering’ on a total of three occasions (Duncan, 1994). The Sexual Offences Act of 2003 introduced a new working definition of a ‘prostitute’: “a person (A) who, on at least one occasion and whether or not compelled to do so, offers or provides sexual services to another person in return for payment or a promise of payment to A or a third person; and ‘prostitution’ is to be interpreted accordingly”¹². The difficulty in parsing “prostitute” is common to all urban regulatory systems; as Elizabeth Wilson argues: “Prostitutes and prostitution recur continually in the discussion of urban life, until it almost seems as though to be a woman – an individual, not part of a family or kin group – in the city, it to become a prostitute, a public woman” (Wilson, 1991, p. 8). Chiu (2006) frames his analysis of the

¹² UK Sexual Offences Act 2003; Clause 51 (2)

deregulation of the Hong Kong sex industry with an anecdote about a legal case in which an undercover policeman posed as a client to collect evidence leading to a conviction for soliciting. The woman involved in the case protested that she had responded to his sexual advances because she found him desirable. The contestation of the case therefore turned on a single clear assumption; ‘a good woman would not do what the appellant did, and therefore it was highly possible she was a sex worker’ (Chiu, 2006 p. 550). As this example so compelling illustrates as cases against sex workers are prosecuted they tend to oscillate between legal definitions of criminal identity (who a prostitute *is*) and criminal activity (what a prostitute *does*) until these inherent tautologies find some provisional, always tenuous, resolution. In Dakar, young women who go out to bars and restaurants unaccompanied, the *gënnkat*, are terrorised by the humiliating prospect of being arrested for soliciting. In Dakar and elsewhere soliciting laws function as a powerful means of controlling women’s access to public space. Despite this diversity of regulatory practices regulatory regimes can be identified by their methodology, as Philip Howell puts it; “regulationism” represents the extension of the state’s powers into new social terrain, through a bureaucratic apparatus of disciplinary surveillance” (Howell, 2004: 231).

In order for ‘regulation’ to *become* an activity that the different actors that I study are *able* to practice, they have had to make local sense of the enormously complex issues that lie behind the deceptively simple project of ‘regulating’ commercial sex work. Before they start, they map the terrain and create new sexual typologies. In every aspect of their practice they apply, and disseminate, their means of understanding the “problem” of the putatively culturally specific ways in which poor women in Dakar sell sex.

Counting Prostitutes in the Colonial City

As David Omissi has argued: “no [colonial] regime could long survive if it treated its subject population as a single undifferentiated mass” (Omissi, 1994, p. 32); the identification of “prostitutes” was a high priority of colonial administrations in Africa. African religion and morality was thought to be rooted in the closed moral worlds of the villages and a move into colonial urban centres was thought to disrupt their social codes of behavior meaning that urban African populations required close surveillance and regulation (Haram, 2005). However, the means of finding women who could be classified as “prostitutes”, which frequently demands that

women consent to or participate in that classification process, was in practice extremely difficult; writing on similar legal projects in India, Phillipa Levine noted that that colonial administrators were “spectacularly unsuccessful” in “deriving a satisfactory definition of what was meant by, and what could be defined under the rubric of prostitution” (Levine, 2000, p. 6).

Tactics for finding “prostitutes” in the city varied considerably across Africa. For example, in the Belgian Congo single urban women or “*femmes vivant théoriquement seules*” (women *theoretically* living alone) were subject to a household tax. The administration of this tax involved what Nancy Rose Hunt describes as a “woman naming crisis” (Hunt, 1991). Women attracted to the opportunities of the colonial city were considered so intrinsically out of place that their definition and regulation seemed to exceed the boundaries of what was institutionally known. “Indigenous” attempts to define and control “prostitution” showed up similar anxieties and multiple and competing explanations. In Northern Nigeria in 1923 the Emir of Kano banned women from inheriting property on the grounds that women who were financially autonomous were becoming “prostitutes”. Accounts of the debates around this term, however, show that in this context: “Autonomous women were perceived as part of a problematic demimonde comprising criminals, members of the *bori* spirit possession movement, effeminate men, rootless former slaves and other deviants from Hausa social norms” (Pierce, 2003, p. 409). Colonial anthropology contributed little to the identification and enumeration of “prostitutes” although African sexual mores fascinated early women anthropologists such as Sylvia Leith Ross who exclaimed that African women “become prostitutes as reasonably and as self-righteously as they would have become typists or telephone girls” (cited in Little, 1973, p. 84).

Colonial regulation in Dakar

The *Loi Marthe Richard* was promulgated in the AOF on 5 December 1946, a government memo to Paris confirmed that the *maisons de tolérance* (regulated brothels) had been closed and the register of prostitutes destroyed. This memo went on to confirm that there was no inclination to bypass the new law as some municipal authorities had chosen to do : « The Parisian Police Prefect may have decided to continue to regulate prostitution despite the passing of the new law. However, no such decision has been taken in the AOF and the authorities barely have any information on the question (having only one « moral inspector » for Dakar) ».

However, the closure of the *maisons closes* in the AOF was not uncontroversial and seems to have been particularly unpopular with the French military stationed overseas. A letter is preserved in the archives signed *representatives de l'armee de terre, de l'air et de mer*” and addressed to the Governor General of the AOF, protested the closure of the *maisons closes*: “The brothel girls – the best of France – were the women we preferred. For us in the military it was in the brothels that we found companions with whom we could speak about France, and in whom we could confide our troubles - often those charming companions made us forget those troubles.”

There appears to have been much debate about how far the redrafted laws were applicable and sufficiently adapted to the conditions of the AOF. In 1952 an article appeared in *Les Echos d'Afrique Noire* from an anonymous contributor, titled “*Va-t-on ouvrir en AOF les maisons closes?*” (Should we open regulated brothels in AOF?) The writer of the letter urges that the policy be rethought as the closure of the regulated brothels has brought into the open the “problem” of young European prostitutes in Treichville, Abijan who “for very little money sleep with Africans” . The writer of the letter concludes “So much for prestige” and suggests that the visible traffic of European prostitution should be limited, suggesting that “it would be more honest to put an end to all this mess and to return to reopen the old brothels”.

“Everyone is exploiting everyone”: “Prostitution”, Mbaraan and Modern Affects

A further barrier to registration is that deciding to register implies accepting that one’s sexual activity falls into the category of ‘prostitution’. Much has been written on the difficulties of defining and delimiting the practice of commercial sexuality in the non-Western world and particularly in Africa (Ankomah, 1999; Bernstein, 2001; Hunter, 2002; Nelson, 1987; Tawfik and Watkins, 2007; Wardlow, 2004; Wojcicki, 2002). Anthropologists studying sexual gifting have drawn attention to the ways in which the exchange of money and goods for sex knits together geographically dispersed communities and have speculated about the privileged and non-stigmatised role of sexual exchange within these local forms of solidarity. In Senegal, *teranga*, a

complex network of intersecting social and religious obligations to one's family and wider community are increasingly acknowledged as incorporating various forms of sexual exchange¹³.

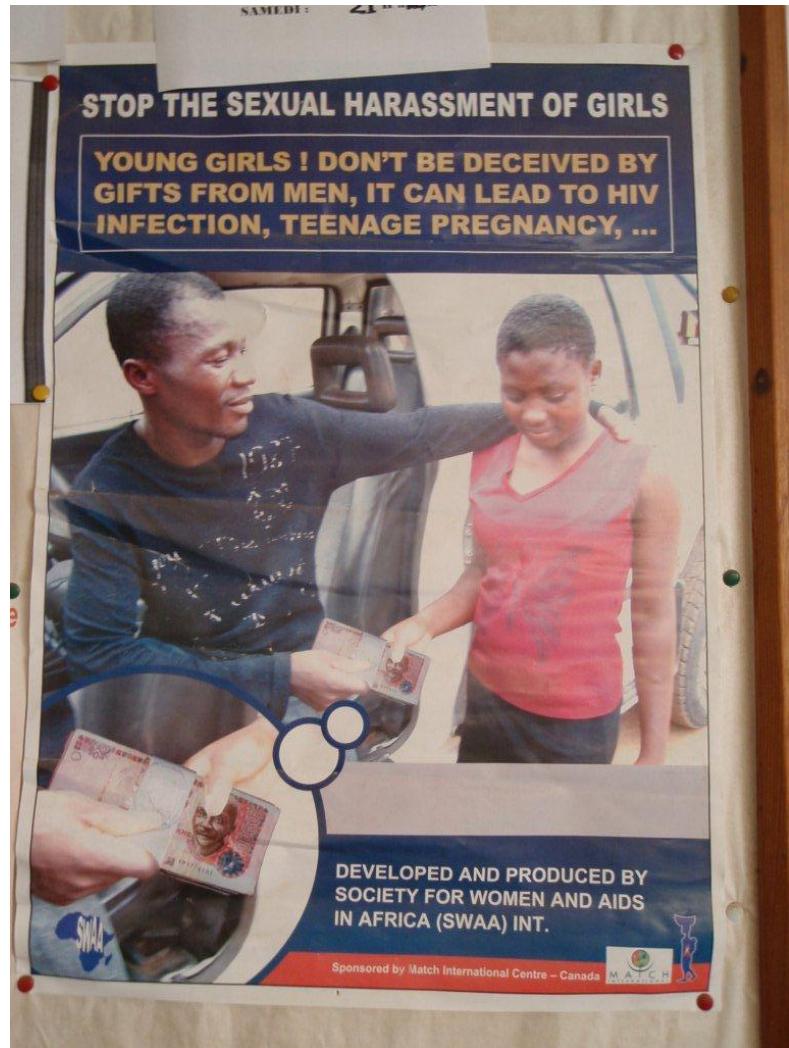


Figure 5 "Young Girls" SWAA Poster in Enda Offices (Photograph, Poleykett)

As Van Eerdewijk shows in her study on young people's sexualities in Dakar "(m)oney is not necessarily antithetical to personal, emotional and intimate bonds, but can in fact be the cement

¹³ Pourquoi cette spécialisation des femmes dans la « prostitution de don ? Massamba, Mbaye (2008) Dakar Life, Issue 5, 26 September - 26 October 2008

through which such bonds are created and maintained" (Eerdewijk, 2006, p. 108). The exchange of money in young people's relationships, she argues, is "part of an interconnected whole through which the meaningfulness of the relationship as well as the gendered sexual identities of both partners are constructed". The existence of different attitudes to cash and gifts within sexual relationships, the 'grey area' so endlessly fascinating to Western anthropologists, is an integral part of the ongoing negotiation of sexual and gendered identities within Dakar and people have no problem in their daily lives in drawing clear distinctions between taboo and non-taboo forms of sexuality. Inevitably, however, scientific representations of 'African' sexual specificity have entered in the common parlance, and *mbaxal* the (exclusively feminine) practice of having more than one partner at a time is now often referred to as 'prostitution' (Eerdewijk, 2007).

Intimate economies in the city are closely linked to the circulation of other social and economic capital. For young women in Dakar marriage is the only or the privileged means for improving one's individual financial situation and for achieving a potential measure of independence from one's family, the point at which young women and men begin their adult lives (Dial, 2008). However, with many young people trapped in an enforced prolonged adolescence without the means to marry, found new households and start families, social norms are in flux. Young women have to *jaayu* or draw attention to themselves (Fall, 2007 p. 153), and this demands a large investment in one's aesthetic appearance. One young woman quoted in Fall's ethnography noted that "*la bataille n'est plus physique, elle est maintenant vestimentaire*"¹⁴. As Deborah Heath argues, dressing well "seems to be conceived of as a legitimate, individualistic goal, but it is a goal that can also be justified within an ideology of long term sexual reproduction, because of its connotations to patron-client relationships and the legitimate display of other's wealth" (Heath, 1992). Appearing in public with new clothes and displaying a certain style and elegance is mandatory for young single women; it is also very expensive, and, in the current economic climate, unlikely to pay off in the form of marriage and independence, at least in the short term (see also Scheld, 2003).

This "grey area" has created a niche for creating new and exciting knowledge about young women's sexual practices and attitudes towards commercial sexuality. More explicit forms of commercial

¹⁴ "The "battle" now is no longer about looking good, it's about dressing well".

sexuality can, in some forms and under certain circumstances, receive a tacit social sanction in Dakar. Whilst there is a lacuna in popular discourse around female sexual pleasure outside of marriage, there is a great interest in female sexuality as it is expressed in the context of a marital relationship. Young unmarried women, whose sexual conduct is closely scrutinised, can, it appears to me, attenuate some of the social risks of dating by soliciting, accepting and publicly displaying small gifts of cash, clothes or jewellery that they occasionally receive from their boyfriends. Various words in Wolof, such as *gënnkat*, literally women who go out, are used to apply to women who work in bars, soliciting for drinks, gifts, looking for personal contacts not always exchanged against sex. *Mbaraan* is the practice of having more than one boyfriend from whom one receives gifts or services. The image in Wolof is one of weaving, that is, women who practice *mbaraan* use their sexuality to weave together various relationships that are important for their wellbeing.

Mbaraan is identified in Dakar as a recent phenomenon and the term itself has only been in circulation since the 1990s. According to Abdou Salam Fall the term designates the “maintenance of close ties with several possible partners, while letting each one believe that the relationship might eventually develop into a closer one, or that the relationship is exclusive ... It is also a term which designates a flux or lack of clarity in personal relationships, an ambiguity which is knowingly maintained in order to string partners along while profiting from gifts”¹⁵ (Fall, 2007 p. 169). The “game” (often referred to as *le jeu*) for young Dakar women is to compete in the city’s sexual economy while still conforming to standards of morality proscribed by cultural and Islamic norms (Morales-Libove, 2005).

¹⁵ « l’entretien des liens préférentiels avec plusieurs aspirants. A chacun, on laisse croire que le choix porte sur lui ou qu’éventuellement des liens d’amour seront noués durablement plus tard ou que ceux déjà noués sont exclusifs. C’est l’espérance contre la générosité, l’espoir contre le compagnonnage, la ruse contre la téméraire fréquentation ou la naïveté .. C’est aussi un terme pour désigner un flou au plan relationnel, sciemment entretenu, pour abuser des prétentions d’hommes ou de femmes en profitant des largesses des prétendants »



Figure 6 Modou Fenn “Birgate de Polisse de Sitoyen”¹⁶

Debates about “prostitution” are certainly lively discursive sites to discuss changes in young women’s sexual practices. These changes in urban social and sexual mores are acknowledged to have made the work of regulating “prostitution” much harder. For example, in one meeting between the police and Enda a senior police officer bemoaned the new order in the city. Once, he said, regulation was easy, you would simply enter a bar or café and arrest any unaccompanied women drinking or smoking, as such behaviour was considered as tacit soliciting. These days, however, some “respectable” young women frequented bars and might even drink alcohol and smoke cigarettes. However as will become clear throughout this analysis “prostitution” is by no means restricted to young or unmarried women. In fact, such women are underrepresented, in particular at the Institute of Social Hygiene where most of the women are older. As Fatou Binetou Dial argues in her *Mariage et Divorce à Dakar*, finding a partner and founding a family is by no means the end of the “battle” that young women describe. Holding households together in the face of economic pressure is extremely difficult and 1 in every 3 marriages in Dakar currently ends in divorce, with some women divorcing and then remarrying the same partner as economic

¹⁶ In this sketch Senegalese comedian Modou Fenn plays an incompetent police officer demanding to see the *carnet* of a woman waiting to hail a taxi. The woman turns out to be the wife of the Chief Commissioner.

circumstances fluctuate. Moreover, in a polygamous society co-wives will often find themselves in precarious economic situations. If a man takes a second, third, or fourth wife who already has children, he is not generally considered to be under obligation to provide for those children (Dial, 2008 p. 62), and co-wives will often need as a result to maintain their own independent incomes.

We're feeling our way through: skilling the mobile clinic

"The culprit, for Bergson, was science and representation which, through their categorisations, their tying of things down, their fixing of things, deprived them of all vitality. In *Creative Evolution* he writes: 'The more consciousness is intellectualized, the more is matter spatialized' (Massey, 2007)

Above I have expanded on some of the difficulties of *finding* women in the city who might fit the legal rubric of "prostitute". This was precisely the set of problems that Enda faced when they set about "targeting" the *clandestine* or unregistered women. In postcolonial Senegal, Enda argued forcefully, the state had ducked its responsibility to provide health care for *all* sex workers by focusing its efforts only on the "self-identified", registered population. It was up to the NGO to "invent" the *clandestine* to research and flesh out the demographics and sexual practices of Dakar's sex workers, and to do that they would first have to find some.

However, when pressed on how they managed to pull off the stunning coup of finding, gaining the confidence of, and eventually persuading the *clandestines* – a group *defined* by their reluctance to identify as "prostitutes" and their mistrust of legal and health authorities – the researchers would often answer: "I don't know", or "we know between us what we do, but it is impossible to explain". Other members of staff would equally struggle to quantify this "connection" commenting on the depth and warmth of the "*relation humaine*" built up between the *clandestines* and the fieldworkers: "If you have seen Awa with 'her' women then you will understand what I'm talking about".

At first, I confess, I had difficulty in listening to these stories – I felt instinctively that they were evasive, that the *meaning* of the fieldworkers' experience was hidden from me. Curiously, despite being absorbed in developing a research strategy that would make clear how programmes unfold "on the ground" and how they affected by "local understandings", I found it hard at that time to relax into listening to the stories that Enda fieldworkers wanted to tell. I would often note in my field diaries after interviews: "boring", or "banal", and would chastise myself for my perceived

failure to elicit data sufficiently “interesting”: picaresque, or full of meaning. This incredible arrogance can be in part attributed to my inexperience as a researcher (and, inarguably to my own obtuseness); but also, perhaps, to the emotional difficulties and pressures of fieldwork (Pollard, 2009); in particular fieldwork conducted within the demanding timeframe of PhD completion. Young researchers are propelled into the field and through fieldwork at a hectic pace under strict instruction to collect “publishable” material. I think that during this period when I stopped up my ears to stories about feelings, emotions and affects I was also influenced by the kinds of “development” research paradigms in which I had been trained which left me with a feeling that I should “read” cultural stories for “sincerity”, and that I should be attentive to and suspicious of narratives. In these contexts it is not always straightforward for a young researcher to “relinquish her will” (Behar, 2003, p. 16).]

In this work I draw out the affective labour, the relationships, the conviviality, and the complex ethos of care which prevails there. These relationships of trust and closeness which are transacted at the clinic and often expressed in kinship terms have become integral to this project. For a long time I was leery of these explanations and irked by expressions of emotion – I ignored what I was being told *again and again*, that “successful” programmes were entirely dependent on the demanding task of building up non-hierarchical, trusting relationships with women in the field. For me at first that did not seem like interesting data. I wanted to “debunk” the stories about feeling and caring and crack upon the “critical” current of what was “really going on” (see Latour, 2004b)

Then I began to ask myself two questions which proved a turning point in my analysis. First, what did it feel like to be a “fieldworker” someone whose job turned upon the creation and maintenance of a “*relation humaine*” – a *human* relationship? What did it mean to be skilled at a job which required that you put in such an excellent performance as a human being, at all hours, and for relatively small remuneration and hope of moving beyond the field and into different kinds of work? Second, what could be said about intimate relationships in institutions if the institutions themselves were spaces in which “care” was slippery and where participation in the rituals and practices of the institution could have ambivalent effects. When I *thought* I was doing work that mirrored the fieldworkers’ own, drawing out stories and sharing experiences and building that

perilous and ephemeral “closeness” – I was in fact listening to the *whole substance of the story*. It seems clear to me now (and also extremely interesting) that as individuals move through increasingly unpredictable labour markets in which they are encouraged to cultivate and market their “situated knowledges” as a set of *key skills*, that we can no longer hope to separate African’s professional lives from the broader question of anthropology: “what is the good cultural life and how is it to be lived?” (Fischer, 2007 p. 37).

Typologies of sex work: para-ethnographic fields

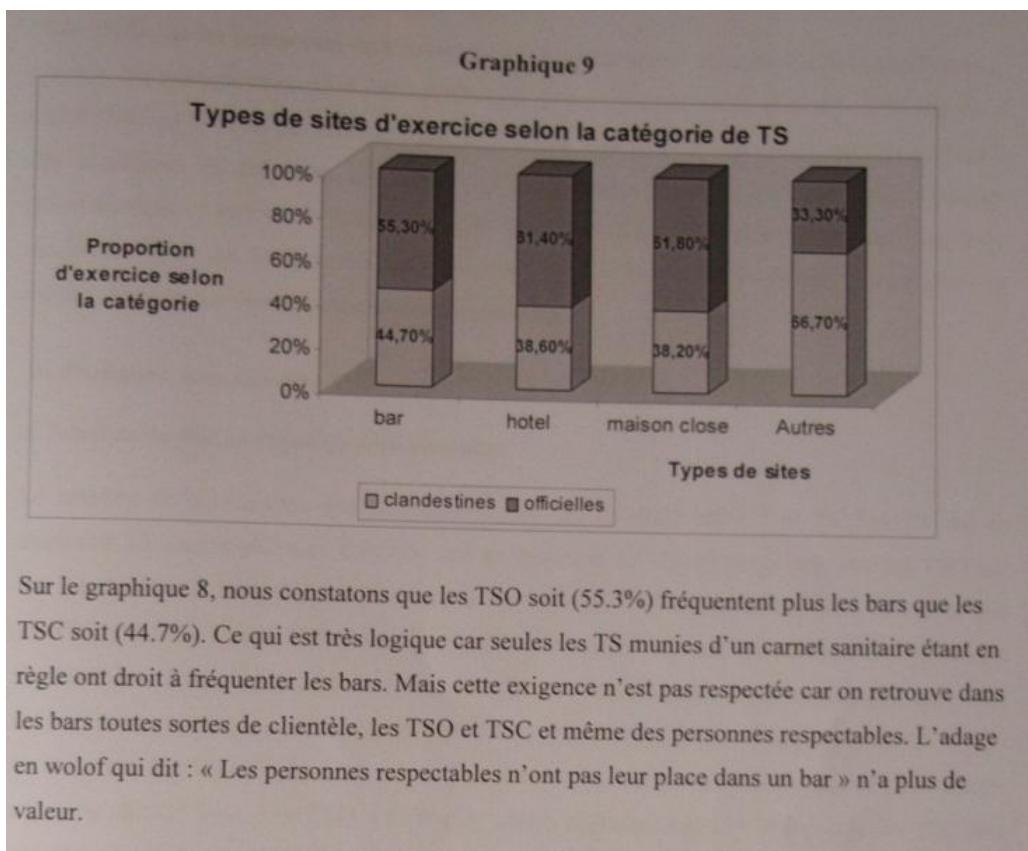


Figure 7 Extract from the “Cartographie de Dakar” 2008 (Enda santé)

Since the 1990s anthropologists have stressed the importance of ethnographically examining the “soft infrastructures” of postmodernity (Fischer, 2007). In this paper I examine a particular kind of

“information aesthetic” (Riles, 2001)¹⁷; a form of NGO action research which has emerged to answer a pressing problem of public health: how to define and identify a “clandestine prostitute”, and the experiences of the Enda fieldworkers as they have experimented with new forms of radical social work in a difficult and highly politicised area of intervention. As Comaroff and Comaroff have argued, anthropologists of institutional life operate in crowded fields in which their own distinctive terrains of expertise has been encroached upon: “the ‘natives’ have seized the terms of our trade, terms in which we once described *them* ... terms that, now essentialised and commodified by ‘others’ one and all, return to haunt us.” (Comaroff and Comaroff, 2005: 152). What are the implications of these para-ethnographic practices?

Based on their experiences of collecting the survey data and combing the bars and brothels of the *banlieues* for women to interview, the fieldworkers came up with a detailed taxonomy of “clandestinité”, the state of being clandestine. One Enda social worker provided the following extremely useful description of the different types of sex workers she had encountered. Here she enters into the problematic which is most pertinent for social welfare organisations, the degree to which women *identify* their activities as prostitution. For these social workers undertaking the extraordinarily difficult task of penetrating these women’s networks, discussing their sexual practices and assessing the risks that those practices pose to their health, they must be able to quickly map women onto known typologies of sex worker and then to persuade these women to recognise their sexual activities as prostitution, or at least to accept the intervention that the NGO are offering under that sign.

“There are married women; there are also official [sex workers] who are married. Sometimes in poorer areas there are more married woman prostituting themselves than young women. Then there are the women in the brothels, in the bars, in the hotels: they might identify as sex workers; the ones that frequent sites of prostitution - they are “professional *clandestines*”. Then, for example a woman who is rents a room, she might receive three or four boyfriends: she might not identify as a prostitute, although what she’s doing is something a lot like it! This is a kind of clandestine prostitution disguised as *mbaraan*. Women who in their *quartier* go about their business and pass as someone of *bonne moralité*: these are the hardcore [*pur et dur*] *clandestines*. There is also another form of

¹⁷ I borrow this term from Annelise Riles’ “The Network Inside Out”, in this work she describes the network as a particular late-modern information aesthetic (Riles, 2000, p. 1).

prostitution: occasional prostitution, this is what women might do, for example, if there is a big festival coming up; one has to dress one's family, one's children, have enough to eat on that day.. and you have no other source of revenue" (Enda, 2007: 49)

Note that in this breakdown of different forms of commercial sexuality the social worker makes a distinction between different degrees of informality, professional *clandestines*, and 'diehard' (*pur et dur*) *clandestines*; the distinction rests here on their willingness to accept an external 'expert' judgement of their sexual activity as prostitution. This 'diagnostic' expertise according to a pre-established typology of commercial sexual practices is professional skill acquired in the field and skilfully marketed.

Another woman interviewed by Enda described herself as practicing *mbaraan rek* (just mbaraan i.e., not prostitution).

You tell them your problem, he can give you something or he can lie to you. You say 'Dama am soxla' (I need something). I need to buy a dress, to go to the hairdressers, to buy breakfast ... I go out with lots of guys. *Mbaraan rek* (it's just *mbaraan*) (Enda, 2007 : 47)

These visual representations of data and the detailed discussions of *clandestinité* are a means of pulling the researchers' embodied and instinctual skills into the realm of signification. As O'Sullivan argues, affects are "the *stuff* that goes on beneath, beyond, even parallel to signification" (cited in Hemmings, 2005: 548). The outcome of NGO research is that *clandestinité* is now a complex epistemological field, in the sense that Mary Poovey uses when she writes of the formation of a *domain* through the "drawing of boundaries and the codification of rules in such a way as to create from what once seemed to be an undifferentiated continuum of practices and ideas new and more specialized conceptual, or imaginary entities" (Poovey, 1995 p. 5). This is the means by which the private intimacies, the uneven and changing experiences of women's complex affective lives and the shifting role of instrumental intimacy is translated into data which can be used to leverage different kinds of political and financial value for the organisation that produces it.

This much discussed 'grey area' where practicing *mbaraan* fades into *cagatu* (meaning selling oneself, closer to prostitution as it is understood in a Western context) is not the focus of my work but it does provide a particular context within which sexuality is interpreted and this makes the

people with whom I work who are involved in the regulation of commercial sexuality uncomfortable with, for example, making a judgment about when women have decisively exited the ‘milieu’ and are no longer engaged in commercial sexual activities, a judgment that intermediary social welfare organisations frequently have to make because it is a key index of the success of their work. Enda santé for example struggled for several years with the possibility of running micro credit programmes which would allow women to establish financial independence and decisively extricate themselves from their financial dependence on selling sex. The problem was that donors would want to satisfy themselves that the sexual morality of women who had benefited from micro credit was beyond reproach. After one incident, a one off but memorable for all concerned, when a restaurant built with micro credit which was found to be functioning as a brothel, micro credit was shelved indefinitely for five years. The organisation finally decided that it was easier simply not to tell the IMF that the beneficiaries of micro credit were sex workers than to be expected to personally vouch for the women’s unimpeachable sexual probity.

“If there’s one thing I know how to do”: knowing prostitutes, soft-skills, and late modern expertise

In 2008 I was attending a management training workshop for staff at the NGO with whom I had begun ethnographic work. Group exercises were undertaken to promote the ability to “think outside of the box”. The workshop was run by a Senegalese woman, but some of the exercises imported from management practice were culturally inappropriate. For example, members of staff were required to project themselves into the future and imagine a successful outcome. This was difficult, even distressing, for the majority of people in the room – evoking an uncertain future is inimical to their Muslim faith and to shared cultural norms. They were encouraged to “overcome” these prejudicial and “backward” ideas and to share stories of how, in their own work, they had conquered these parts of themselves that were holding back their professional and personal development. One senior member of staff, Mariama, spoke about how her faith and her personal beliefs had been challenged when the organization started working with MSM (men who have sex with men), but she had found a means to compartmentalize those feelings of distress and had to craft and maintain an appropriate professional self. “I came to understand”, she explained, “that in coming to work I had to set aside that “Mariama”, with her cultural and religious baggage, and I had to be a different person”.

I was struck by how these management narratives revolved around rejecting “culturally specific” traits in the pursuit of a greater “professionalism”. For example, the woman leading the workshop as she concluded the “thinking outside of the box” exercise, stated that, in her opinion, the difference in national development between Africa, China, and postcolonial India could be explained by African’s inability to “think outside of the box”. In order for their countries to achieve similar levels of economic and social development, the onus was on Africans to change themselves and becoming different kinds of subjects – creative, questioning, and ambitious. In other words the workshop was a space where “knowledge of oneself [constituted] the fundamental principle” (Foucault, 1997b, p. 228). Acknowledging the aspects of oneself that might hinder the successful performance of professional identity was a vital part of moving forward and ‘successfully’ completing participation in the workshop.

In the afternoon session members of staff were encouraged to step forward and reflect on their immanent skills versus their more formalized expertise. The object was to encourage people present to engage in reflexive interrogation of what they had in their “tool-kit” beyond educational qualifications, IT skills etcetera. In order to elicit this reflection the coordinator asked everyone to list skills they “knew” they could do, and skills they “didn’t know they knew they could do”, a formulation which caused some understandable confusion.

Rama, one of the fieldworkers I had been working with volunteered to share with the group the list of skills she had drawn up. Ignoring the rather strange rubric of the task, she stepped forward with the confidence of a practiced *animatrice*: “if there is one thing I know how to do”, she said, “it is to recognize a sex worker”. This knowing statement caused much hilarity in the room as she embroidered skillfully on the comic potential of her theme, fielding questions about whether or not she saw any sex workers in the room (she did not), and waxing mock-mournful about her converse inability to find a decent man. Everyone in the room knew the jokes, but her timing was razor sharp and the performance was irresistible: the room was in uproar.

Rama made little attempt to hide the fact that she thought the seminar was a needless distraction from the “real” work in the field. Her hijacking of the proceedings was tactical. However, I found the timing of her intervention interesting. What she had particularly taken exception to was the

attempt on the part of the workshop coordinator to draw out the “soft” skill of her profession. Rama, like the other fieldworkers, did not think that she needed to be told that her skill drew on unconscious, unmediated skills – knowledge at the level of the body – nor did she feel that she needed to be told that this skill should be *recognised*, for her, it was simply what she did and it did not need to be drawn into an externally defined mode of “professionalism” to be validated.

Conclusion

In this chapter I have focused on some of the historiography of regulation which seeks to draw out how troublesome women, the *femmes isolées* or women out of space in the city, have been identified and intervened upon in different historical times and different geographical spaces. I understand the complexities of “fixing” identities and also that those identities *need* to be fixed in order to build solutions. However, I would add that public health literature *has* a name for *clients* that tries to deal with “drift” and with complicated intimacies they are called “*the boyfriends*” (for a further discussion, see Ratcliffe (1999)) an identity that clearly associates the sexual habits of women’s male partners on a par with “respectable” relationships. Attempts to understand the *flou* – the ambiguity and complexity of young women’s flexible and malleable intimacies must be understood as continuous with previous and parallel efforts to regulate those intimacies and therefore as reproducing some deeply problematic assumptions about women’s sexuality and the autonomy they can be granted.

I have also discussed some of the knowing practices of the NGO workers who create novel typologies of commercial sexuality out of the close affective relationships they develop with the women with whom they work. The new and more ‘specialized’ knowledges that Enda produce are a result of engaged ethnographic practices that make the quantitative data about a number of bodies arranged over a number of spaces “speak”. The fieldworkers ethnographic practice, both in the embodied in-field interactions and in the stories they tell, “palpate” differences that are subtle and obscure. Todd May writes on Deleuze’s concept of the palpation of difference that:

“Concepts do not identify difference, they *palpate* it. When doctors seek to understand a lesion they cannot see, they palpate the body. They create a zone of touch where the sense of the lesion can emerge without its being directly experienced. They use their fingers to create an understanding where direct identification is impossible ... We might say that

palpation ‘gives voice’ to the lesion. It allows the lesion to speak: not in its own words, for it has none, but in a voice that will at least not be confused with something it is not” (May, 2005, p. 20)

Having sketched out in this chapter some of the enormous difficulties inherent in trying to define prostitution, and also how successful Enda have been – at least on paper – in enumerating the subtle differentiations in contemporary commercial sexual practices, I turn in the next chapter to the institutional history of the mobile clinic as a target response to clandestine sexuality. I also ask the key question that an engagement with ontopolitics provocatively insists up – *so what?* What are the effects of these “novel” identities circulating and what opportunities do they open up, and close down, for women in the city?

CHAPTER FIVE: THE STRATÉGIE AVANCÉE: TECHNOLOGIES OF GENDER AND THE MOBILE CLINIC

“If you’re going as far as the bars to find them; that means you’re dealing with a *clandestine*”
Programme Officer, FHI Dakar

The Enda-santé mobile clinic is an innovative, highly successful, and well-regarded HIV/AIDS intervention targeting clandestine or unregistered prostitutes in Dakar’s *quartiers populaires*. The mobile clinic model has since been rolled out in Mbour and Ziguinchor in Senegal and in Guinea Bissau and Cape Verde. In all of these locations it has proved a highly adaptive and flexible tool for generating deep data and compelling stories about commercial sex workers and their struggle for health in impoverished communities, as well as bringing high quality care to women who in many cases have never before been consulted by a biomedical doctor. The data derived from the clinic programme has allowed Enda-santé to play a major role in legal, social and medical debates around “*clandestinité*”, addressing questions that are considered among the most urgent in public health circles in West Africa. Daouda Diouf, the director of Enda-santé, extrapolating from (largely qualitative) studies carried out in 2007, has estimated that around 80% of the women involved in commercial sex work in Dakar are *clandestine*, that is, practicing covertly and not registered with the state. This indicates that the vast majority of sex workers are underserved and only have access to the healthcare and health information that they can find and pay for themselves. The findings also suggest that current levels of sero-prevalence among clandestine sex workers in Senegal have been significantly underestimated (Foley & Nguer, 2010).

I have already dwelt at some length in Chapter Four on the role of the fieldworker as lay ethnographer – gathering subtle and complex data and leveraging their ability to “recognise a sex worker” into different kinds of research and intervention work in the pursuit of a sustainable career in the NGO sector. I thought about NGO ethnography as a particular kind of information aesthetic and dwelt on Enda’s success in making Dakar’s “social dynamics visible” and then using these skills to build relationships with international organizations (Simone, 2004, p. 47). In this

chapter I present the history of the mobile clinic as a microhistorical case study, tracing the development of the project from conception to execution to its protracted and untidy end in Dakar. Running in Dakar from 2004-2010, the mobile clinic project constitutes an invitation to think about “what kinds of bodies are being constructed *right now*” (Braidotti, 2006, p. 198) by contemporary and fast-changing horizons of knowledge and public health practice.

Marx wrote that political economy is indifferent to “spectres outside of its domain” (Marx, 2001, p. 120), those individuals who are not active and productive in the informal economy and therefore considered suitable only for the disciplinary gaze of the “doctor, the judge, the grave digger, and bum bailiff” (*ibid*). However, as Michael Denning (2010) argues, the reproduction of this discourse through literatures on “bare life” and surplus populations “sometimes has a false immediacy, seeing a state of exception or emergency in what is unfortunately a state of normality” (Denning, 2010, p. 80). In this chapter I take women’s projects of living and working beyond the reaches of state regulation and state welfare as banal. I examine how far the mobile clinic programme is able to confer social and medical goods upon the women it engages without entering into relationships which function coercively, or which impose social and sexual identities upon women that they do not recognize.

As an NGO-run, bilaterally funded health and development programme targeting the *clandestine*, the mobile clinic deliberately contravenes state policy on the regulation of female commercial sex work. As such, the mobile clinic holds out the promise of an ambiguous kind of membership which lies somewhere between “signing up to be marginalized” (Renaud, 1997, p. 145) and going it alone. In chapter six I will reflect again upon the potential social and personal costs of entering the regulatory system – of being recognized as and gaining the identity “prostitute”. Here I ask: what is potentially lost and what might be gained in being recognized, although, in this case recognized by a non-state actor.

This chapter presents an historical account of the opening and the closure of a new bureaucratic category – the *clandestine* – and the ways of knowing and the technological apparatuses that sustain this process. There are three main themes which run through this case. First, I think about *becoming formal* – I am particularly interested in the ways in which the mobile clinic redraws

boundaries and re-works, through different kinds of practice, the parameters of the informal, illegal and illicit. I tell the story of the mobile clinic through interview data with the physicians, fieldworkers, researchers and office staff who fought for the legitimacy and recognition of their radical project. I then think about the quality of the formality that is produced – the clinic staff and bureaucrats explain it is a function of the “trusting” relationships that have been maintained over time. What is this “formality” which guarantees the clients of Enda’s mobile clinic the right to move more freely about the city, to associate with one another, to use health services that they would once have avoided? Through what affective relationships is this “formality” – a space for the women that the NGOs must negotiate, carve out, and defend – maintained? Second I approach the *enactment* of the difference of the *clandestine* through one micro-vignette of provisional categories forming in the context of a preliminary intervention in the field, here I look at the entanglement of social identities and the mobile clinic as a piece of fluid technology. This analysis is related to the larger project of exploring how gendered and class differences are “made and unmade in sociotechnical practices” (Moser, 2006 p. 537). Building on the observations in the previous chapter about NGO ethnography as a knowing practice, I include the data gathering techniques used by the Enda fieldworkers as a sociotechnical undertaking. Finally I then think about the kinds of knowledge that is produced out of these interactions – what is that “falls out” of the analysis?

The material presented in this chapter is based largely on participant observation with the mobile clinic and on formal and informal interviews with the Enda fieldworkers: “Astou”, “Mariama” “Fatou” and “Mamadou”, and the mobile clinic doctors: “Dr Ly” and “Dr Ndiaye” (one male, one female). I have chosen not to anonymise the comments made by the Director (Daouda Diouf) and Deputy Director (Fanta Diop) of Enda-santé in the context of formal, recorded interviews.

Becoming formal with the NGOs

The pre-history of the mobile clinic

The idea of a mobile clinic targeting women involved in commercial sexuality who did not choose to register with the state emerged out of a set of distinctive intervention traditions in Senegal. First, there is Senegal’s longstanding national level emphasis on the diagnosis and treatment of sexually

transmitted infections as a key part of the fight against HIV/AIDS. This thread can be traced back to the 1960s and considerable experience has been accrued in the clinical and syndromic diagnosis and prompt treatment of STIs. The emphasis on STIs encourages an interventionist, “outreach” approach, stressing regular contact based on trusting relationships – rather than single contact based on testing. Second, Enda acquired considerable experience in the 1980s and 1990s working closely with the CNLS. They were given an early mandate to distribute condoms widely and indiscriminately. This gave the organisation an early insight into the kinds of people who were approaching them for information on the new disease, and in particular the high proportion of concerned women who were trying to find out what steps they could take to protect themselves.¹⁸ Third, the particular intervention modality that Enda and others worked with in the early stages of the epidemic was a piece of mobile infrastructure – the *camion* (truck). They took the *camion* out in Dakar and Senegal, spreading a general prevention message and mobilising large populations. When they began to move towards more targeted “boutique” interventions they drew on some of their experiences with the *camion*, including reflecting on how the programme could best be integrated into static sanitary structures. More generally people at high level planning positions in Dakar reflect on this progression as a story about the progressive differentiation of the public, moving towards a more sophisticated and nuanced idea of “targeting” – and therefore a more effective intervention. In an interview with the director of the ANCS, for example, he notes that while civil society actors were once only engaged to find or to rally [*rassembler*] a group of people who would then passively receive a medicalised discourse, civil society have now rejected and redefined that role.¹⁹ Finally, the other tradition that can be discerned in the mobile clinic is the “community conversation” consciousness raising model of intervention plus peer education, which

¹⁸ I am grateful to Charles Becker for drawing my attention to this point.

¹⁹ “En fait je pense que ce qu'il faut vraiment remarquer c'est qu'il y a quand même une évolution de la société civil, aux premiers heures de la réponse au VIH c'était une réponse beaucoup plus orienté sur le médicale, et les acteurs médicaux en fait pensaient que la société civil c'était des petites association au niveau des dispensaires, au niveau des hôpitaux, ou des petits associations qu'on mobilisé si on avait besoin par exemple de faire une communication, on leur demande juste de rassembler tout le quartier, ils rassemblent les médicaux viennent, ils délivrent leur message après on leur dit merci, c'était gentil, vous êtes bien, etcetera mais la société civil a évolué a beaucoup évolué au Sénégal, elle s'est restructuré, elle s'est bien organisé, elle a mis en place des dispositifs institutionnelles pour son développement” [Interview M. Thiandoum, ANCS: 06/07/09]

came from the community based approach to urban development adopted by Enda as an organisation since its beginnings.

People from outside Enda often group the project into the category of the *stratégie avancée*, that is, they identify the mobile clinic with the broad policy adopted the 1980s and 1990s by public health officials in Senegal and elsewhere in Sub-Saharan Africa of moving out *sur le terrain* to make direct contact with the people and to deliver essential services such as vaccination. The *stratégie avancée*, in other words, is an emergency outreach response to a pressing public health problem such as the need to achieve herd immunity which cannot simply be left to people to voluntarily present themselves. Within Enda the mobile clinic programme is thought to belong to a quite different paradigm one which has less supplanted the *stratégie avancée* than exists in a parallel world to official state public health policy. As Daouda Diouf explained: “the *stratégie avancée* is a military term .. which was taken up by the public health services .. For us in contrast *stratégie avancée* is what we do every day! Our work is going out and working with communities! The strategy that we tried to put in place was one that would be responsive to this particular population who worked at night, who had the profile of a sex worker – but during the day they are mothers; they have the profile of, let’s say, an ordinary member of society” [Interview, DD].

The Cartographie

The central methodology of the mobile clinic programme is quite straightforward. As I touched upon in Chapter Four, the clinic social workers go out into the poorest parts of the city and begin the construction of an ambitious urban ethnography, the *cartographie* of commercial sexuality. This document, which is renewed every two years, is both a piece of independent research and a document which Enda use to plan the mobile clinic interventions. It involves firstly a mapping of bars, brothels, and sites of commercial sexuality activity, which are found through talking to people on the ground, walking around the neighbourhood, closely questioning “women who go out at night” about the kinds of places they frequent, and – sometimes, although less often – asking the police. Three organisations in the field with whom I have discussed this process each have a particular approach to “finding” the *clandestines* and specific techniques they use to do this. The Enda approach mimics that of AWA (discussed further in the following chapter) – whose field

approach was based on finding and persuading unregistered women to register at the Institute of Social Hygiene.

Once the individual site-based ethnographic investigations are collated into the *cartographie* of Dakar the finished product is a flat document which shows the distribution of sites of vice across the whole city. This document is capable of demonstrating the dispersal of women across the city in interesting ways. For example, one of the most interesting findings was that working class women often club together and pool their income to rent attractive, furnished flats in high income areas such as the well-heeled coastal suburb of *Almadies*. This allows them to work far away from their homes and to access potentially wealthier pool of clients. This is just one of the insights which was capable of breaking up some of the intuitive connections between low-income areas and poor women's stigmatised sexual practices.

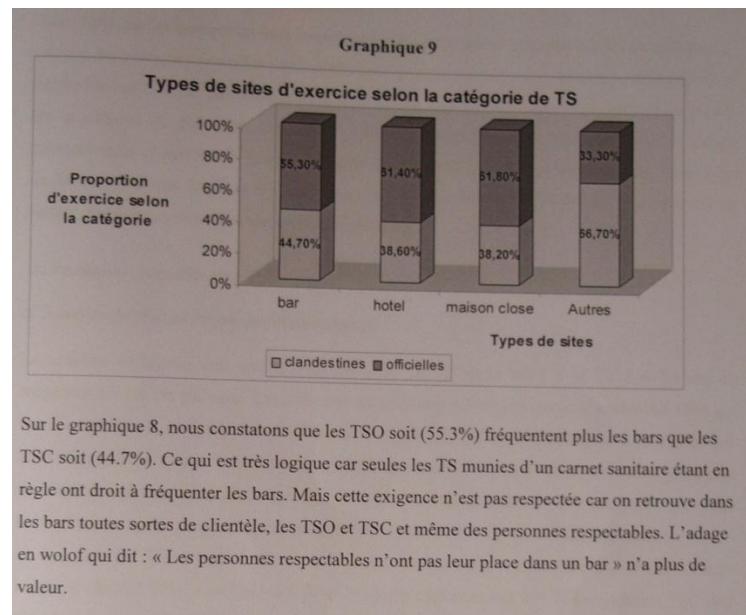


Figure 8 Extract from the *Cartographie de Dakar*, 2006

Another way in which the *cartographie* as an innovative mixed-method piece of research produced a powerful narrative about sex work in the city was that it showed that many women involved in commercial sexuality were concentrated in parts of the city where the state biomedical care was

either non-existent or dysfunctional. In other words, these women were living “off-the-grid” in terms of their access to biomedicine. Indeed, Dr Ndiaye noted that when many of the women were consulted for the first time at the mobile clinic, they had never before seen a biomedically trained doctor. He further estimated that on average in a group of ten, six or seven of the women would be living with sexually transmitted infections, or other untreated gynaecological complaints such as bacterial vaginosis that in some cases were causing them chronic pain. In this way the *cartographie* has allowed Enda to extend the definition of “vulnerability” to capture the condition of vulnerability to which women are exposed by their inability to access high quality, medical care without the fear of stigmatisation, as Fanta Diop noted: “these women are also ‘vulnerable’ in terms of their lack of access to medical care” [Interview, FD].

Once they have completed the research for the *Cartographie* the NGO-ethnographers then begin to work the research data they have compiled by returning to the field with their new maps and with a new agenda. They ask women to form small groups relying on the women to recruit their peers and ‘snowball’ the intervention. Once these groups of women are formed they are taken through a specific itinerary of successive sexual health check-ups provided by the mobile clinic. The women are then encouraged to take the HIV test and offered some further specialized interventions that respond to needs articulated by group members. Enda are relatively open to following the requests that the women make, even if they do not slot obviously into a prevention public health format. For example, many groups requested information sessions that would help them to understand the biological processes behind their menstrual cycle, and Enda hired doctors to provide clear and accessible information. The “reproductive and sexual health” remit was sufficiently flexible that women were able to access information about their bodies that they could not have got any other way. Beyond this training there are a bespoke set of development interventions, usually involving the most “assiduous” members of the group, or the women who have expanded the group through recruiting their peers, and usually being the NGOs arranging for microfinance for a small business initiative.

While some fieldworkers struggled to meet the very demanding schedule for recruiting and supervising new groups, Enda have been very successful in making contact with *clandestines*. At

Family Health International the organization have borrowed some of Enda's research methods - and their contact lists - for carrying out sentinel surveillance studies.

Controversial Beginnings

The first and most significant challenge that the project workers faced when beginning to go out into the city with the mobile clinic was overcoming to the initial suspicion on the part of women that the social workers had identified in the mapping phase. As Dr Ndiaye recalled, when women arrived for their first consultations they were very anxious: "They were asking themselves, is this the police? Is this regulation? When you see a big white vehicle the first thing you ask yourself is 'Is this a police van?'" However, after a few months and several return visits the women began to trust that this service - initially inexplicable because free and apparently without obligation - did indeed seem to fit the fieldworker's descriptions.²⁰ Both Dr Ndiaye and Dr Ly remembered that after a few visits the women would agree to share their real name and would admit that they had given a false name on their first visit because they were suspicious and reserving judgment. Thinking back to these intimate moments Dr Ndiaye said: "It was extraordinary! We knew then that this was a breakthrough, that they were beginning to trust us - that is my most powerful memory of that whole time".

However, the sex workers were not the only ones who needed to be persuaded. At the beginning of the project it was relatively controversial - it facilitates law breaking because it allows women to access high quality medical care while bypassing the state clinic. Where Association AWA had grown out of the state clinic and adopted the methodology of working through, with and across the state, Enda covertly opened up a parallel system - with its own doctors, its own funding, and its own means of logging and monitoring its target population - and all in parts of the city that the state often claimed were either too dangerous to police, or which contained a population too resistant to biomedicine to be usefully targeted by a health intervention.

²⁰ Ayodele Samuel Jegede in his account of the failure of the Nigerian polio vaccination campaign quotes journalist John Murphy on the suspicion and hostility aroused by *free services*: "The aggressive door-to-door mass immunizations that have slashed polio infections around the world also raise suspicions. From a Nigerian's perspective, to be offered free medicine is about as unusual as a stranger's going door to door in America and handing over \$100 bills. It does not make any sense in a country where people struggle to obtain the most basic medicines and treatment at local clinics." (Jegede, 2007)

Sometimes the police targeted the clinic reasoning that it was an efficient way of picking up unregistered sex workers. Clinic social workers were harassed and Astou and Mariama were themselves arrested on several occasions on a ‘soliciting’ charge, a painfully humiliating experience that underscored the high personal and social cost of this kind of work. After a few of these incidents Enda gave the doctors and social workers a laminated badge with their photographs on which they carried at all times while out in the field. As Dr Ndiaye recalled, “the badges showed that “we were working *officially* for Enda and we were working to protect populations vulnerable to HIV/AIDS”. On several occasions the women from the groups were *rafleé*, that is, picked up on the street on a soliciting charge. In order to maintain the integrity of the groups – and the credibility of the organisations in the eyes of the women – the social workers went down to the police station and exerted some of their considerable negotiating skills in order to explain that these women were under a certain protection and that they were participating in a medical intervention of some importance.

Slowly however and as the programme began to attract more interest based on the data it had gathered, these parallel systems began to be professionalized and institutionalised. Individuals were approached to help the programme continue to function and these approaches were successful largely because of the warm working relationships that exist between civil servants, high ranking police, civil society leaders, relationships of mutual regard and shared education and cultural background and a desire on the part of state functionaries to participate in something *modern*, innovative, and to network and meet the people who this project will bring into their world, donors, experts, auditors, researchers. In Dr Ly’s words, the state began to see that the NGOs were “not saboteurs” The clinic project was then scaled up with the investment from two donors and brought into line with extra local ethical protocols governing AIDS interventions. This meant compromising one aspect of the project which had been very close to the heart of its founder, using the clinic to bring the HIV test to poor women who used the service. This was abandoned however because the clinic could not guarantee privacy and information security or conformity to international ethical guidelines on testing. In order to ensure conformity to these protocols the team was professionalized and a full time auditor was hired. Donor logics were thus woven through the project, changing some of its orientations.

Finally the state system found the clinic programme very useful as it represented a cluster of interest and experience that it could draw on when it elaborated national policy. Representatives of Enda participated in the re-elaboration of the national treatment algorithm for sexually transmitted infections – a technology that bound together all non-etiological diagnoses for STIs in Senegal under one single process of diagnosis and treatment (see Figure 9 below). This meant that the procedures followed on board the mobile clinic were exactly the same as those at every government-run *poste de santé* – even if staff had only had some training, the *protocols* were clear and easy to follow and accessible at every clinic. Women who knew about the service then made a choice between two paths to something like formality; as registered sex workers or as clients of an exemplary and well respected NGO. Moreover the mobile clinic programme which had begun covertly now had a veneer, a patina of formality that the state clinic lacked. The programme also appeared more efficient and more visibly regulated. Where social workers at the state clinic were unable or unwilling to protect official sex workers from police harassment for example, Enda social workers got out of bed in the middle of the night to hector policeman who had arrested their *clients*.

Compared to the quality of the medical services provided on board the mobile clinic, the state starts to look and feel ramshackle, informal and the norms under which the state operate start to feel decidedly arbitrary. Moreover the affection that the women who have thrown in their lot with Enda feel for the fieldworkers and the programme is *real*, one of the women in the Xaar Yalla group has a child named Enda. The clandestine sex workers who were interviewed by Foley and Nguer (2010) were enthusiastic about the mobile clinic: “Typical comments included: ‘Ever since we have been working with ENDA we are no longer sick, because they come to our neighbourhoods once a month and treat us.’ The participants also mentioned the invaluable legal advocacy that ENDA-Santé offers when a sex worker is detained or arrested without cause. As one clandestine sex worker explained: ‘It is hard to work underground, but now with ENDA-Santé we have fewer problems. If the police detain us they will come get us out of jail.’” (Foley and Nguer, 2010: 332)

Douleur abdominale basse chez la femme

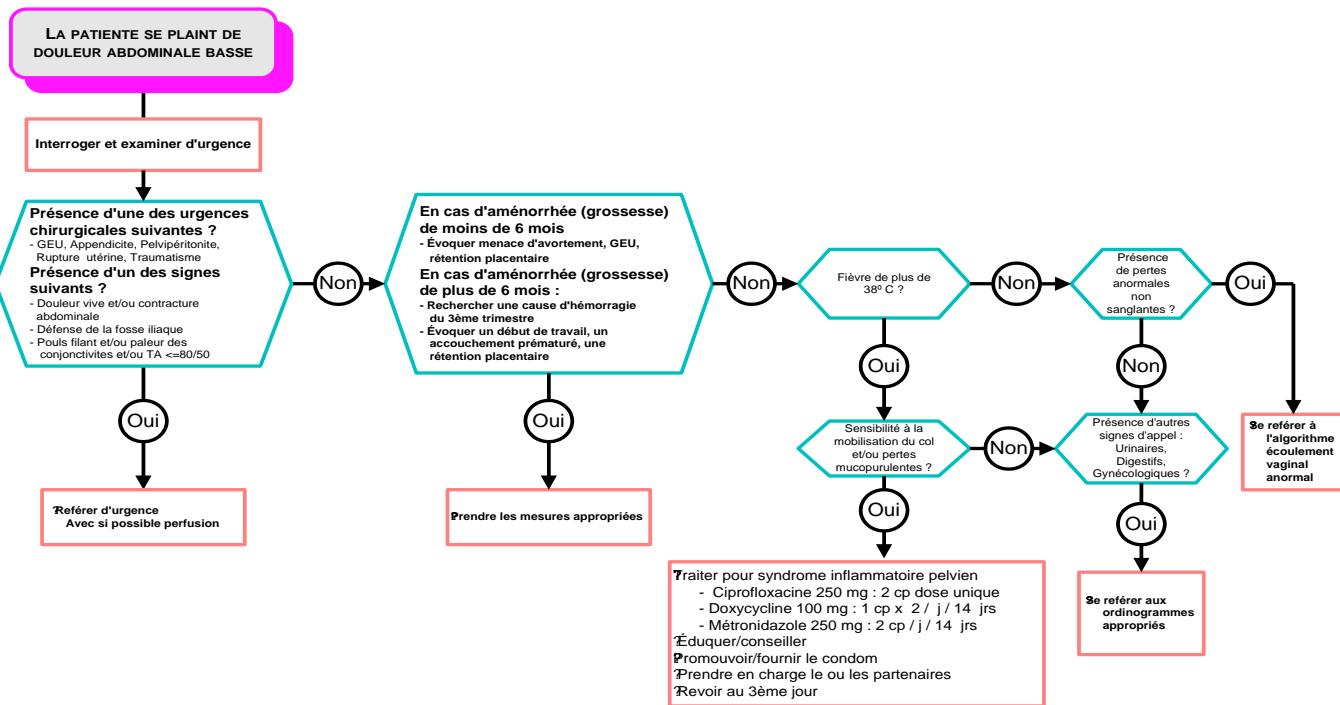


Figure 9 Guide de Suivi Medico-Social des Travailleuses de Sexe, Ministere de la Santé et de la Prevention

Enacting the Clandestine

One night I went out with Mamadou to visit one of the groups that he was beginning to draw together in *Xaar Yalla* – an impoverished inner city suburb dominated by informal housing which despite its proximity to “downtown” peninsular Dakar is difficult to access because of the haphazardly planned informal housing that predominates and the lack of infrastructural investment. Mamadou had arranged a *causerie*, an introductory conversation which would allow him to meet the women who had been identified and invited by the elder peer educator – Enda’s point of contact in the neighbourhood.

When we arrived Mamadou conducted a quick roll call, checking names off the list that the peer educator had given him over the phone that morning; he then opened the *animation* with a brief discussion explaining his role and the role of Enda-santé. He invokes the rules of *teranga*, or social

solidarity and reciprocity: if you had a problem with money, he noted, you could go and ask your brother, or your mother, but because the problems that women are facing in the *quartiers populaires* in a time of crisis (*crise bi*) are so complex and so severe that communities must seek help from outside agents to try to resolve them. The assembled women nod in agreement as he lists the problems that poor women in Dakar face: poverty, family responsibilities, poor health, *ordonaanse*, premature babies. Skilfully Mamadou inscribed his explanation of the work that Enda-santé do within the norms of social and community solidarity. He clarifies that Enda don't work with people who have money, but with people "who are poor" [ligéeyunu ak ay *riches*, danuy ligéey ak ay nit ku ñakk ndoole], or with women who are in a difficult situation [ku nekk ci jafe jafe]. At this stage neither sexuality nor prostitution are mentioned.

Mamadou then tells the assembled women that the talk in the group discussion around sex and sexuality will be direct and that they should avoid using the evasive terms for genitalia: *taat* and *kanam*. He makes a joke that plays on the doubled meaning on *kanam* (face), telling a story about a hapless woman who was instructed to apply cream to her genitals and mistakenly put it on her face. The women react to this with a mixture of hilarity, on the part of the elder women, and shyness, on the part of the younger. Mamadou then runs over the three modes of the transmission of the virus [*sey*, *dewet*, *meew*] and then expands carefully upon *sey* – which translates to marriage, to intimacy, and also, evasively, to sexual relationships. He explains vaginal and anal transmission – mentioning anal sex a young woman asks "are there women who do that?"

Mamadou then sketches out the services that Enda offer. He stresses that women will be expected to take advantage of the full range – in particular *dépistage* (the HIV test). He tells the story of a woman who was so ill that she arrived at the clinic to take an HIV test pushed on a *pousse pousse* – "Ndeysaan", the women murmur sympathetically – and now that she knows her HIV positive status she takes her antiviral medication [*jel garab*] and has even, as a member of an association of people living with HIV, travelled around the world going to conferences and telling her story. The women listen, rapt, to this story with its wonderful, perverse, reversal of fortune.

Because every group is required to have a reasonable balance in terms of age most *causerie* encounters are a space of dense negotiation around seniority, femininity, sexuality and expertise.

The understanding of sexuality as a highly “expert” set of practices is a particularly feminine and, perhaps, particularly Senegalese phenomenon, it is certainly not limited to commercial sex workers. Young women talking to each other about sex, relationships and sexuality will often ask: “*danga def ba mu def bu baax?*” [literally, are you doing it until you do it well], and there is a very highly developed discourse of feminine erotic expertise, using the tools of seduction: *curaay* [incense] and *bin bin* [beads worn around the waist]. The Senegalese historian Mamadou Diouf attributes this understanding of feminine sexuality to the development of a Creole culture in colonial St Louis. Mixed race women who were the “mistresses” of French administrators and Lebanese traders developed an idea of sexuality *as leisure* and cultivated a separate feminine identity (Diouf, 2009)

The talk amongst the older women is frank and ribald and directly acknowledges their sexual experiences. When Mamadou says that they will talk about female genitalia one woman asks if they will talk about male genitalia. “You know what that looks like”, the *animateur* parries, “didn’t you look at it before he put it inside you” [*yow, gisuloo ko balaa mu ko fa dugg?*]. The younger women are much quieter and defer to the boisterous older women. This dynamic between older and younger women is a facet of all interactions in Dakar, determined by seniority and the need for young women to show respect to their elders. The specifically feminine aspect of this experience, in single gender groups, also breaks down around the highly differentiated ways in which femininity is understood and performed and different points in the life cycle. So, the *animateur* refers to the younger women as – trying to draw them out - by addressing them as *janq* [*janq yi naka mu?*] and then more jokingly as *les disquettes*²¹. *Janq yi* is not a wholly respectful term of address but it produces a pleasure of recognition among the older women, indicating that women in the room are differentiated by age. He acknowledges the seniority, and the desirability and power, of the older women by calling them *diriyanke*. Nyamnjoh notes that in the population imagination in Dakar, the word *diriyanke* reflects: “the word reflects the dignified, slow and gracious gait and middle-aged elegance of the Senegalese lady at her best. In other words, the *diriyanke* is a ‘*grande dame*’ and it is worth noting that, nowadays, the label also applies occasionally to men of the same

²¹ *Disquette* is a term which refers to a young woman and to a young woman’s (idealised) body type.

age range as their women counterparts, who love to dress in fashionable, expensive 'traditional' outfits and who are equally concerned about their looks and gaits." (Nyamnjoh, 2005, p. 300). The *diriyanke* is also known for her mastery of the "traditional kit for seduction and eroticism in Senegal" (*ibid*). Hudita Nura Mustafa says of the specific femininity of the *diriyanke*:

The eroticised and commercialised femininity of the dirriankhe is a public expression of the sensual beauty of women previously restricted to the domestic sphere - the household and extended kin. This ideal guides the consumption and display of middle-class women, who perform their gendered identities through elaborate and skillful dress in public ceremonies, primarily for the approval and appreciation of other women - to gain friends and peer support among these women, to establish their status, and so on. (Mustafa, 2006, p. 25)

In Chapter Four I discussed at some length the kinds of typologies of clandestine sexuality produced by the mobile clinic and the knowledges in and of the body mobilised to produce these typologies. I argued that these knowledges engaged the invention of the clandestine as a new and distinct bureaucratic category - focusing on promiscuity, "hiding", and disavowal. In the analysis that I present above, I delve into the space of and around the clinic to think about how these categories *emerge* and *then circulate* in precise material spaces.

In referring to the women as *diriyanke* and as *disquette* the *animateur* is being respectful. He is marking them out as women capable of conforming to these idealised feminine "types". The *diriyanke* lifestyle, her cultivated femininity in its distinctively "Senegalese" register of ostentation (carefully tailored Malian *basin* fabrics, Western branded handbags, and Moroccan and Mauritanian gold jewellery rather than "American" style clothes or the conspicuous consumption of commodities such as mobile phones) remains materially beyond the reach of the women of *Xaar Yalla*. The *animateur* is complicit in the women's public performance, even at this private and intimate moment when that public performance begins to fray and the women begin to cautiously set aside their public personae. More significantly, he is communicating that although they are caught up in a development programme targeting "commercial sex workers", he understands their sexuality as firmly inscribed within the parameters of "acceptability". The idealised *diriyanke*, through her wealth, her discreet cultivation, her age and her intelligence, has considerably more room for sexual and social manoeuvre in terms of expressing and enjoying her sexuality than a young woman or a woman from a different class background.

This courtesy is one way then of signaling that he has picked up on the subtle feminine performances, and he quickly slips into their teasing, bantering register, a far more successful mode than the awkward exhortations to “disclose information” or to “be frank” sometimes employed by NGOs. At another meeting Mamadou framed Enda’s services as being available to widows, divorced women, and single women²². The most significant aspect of these categories and one which immediately struck me is that they are the *categories of demographic vulnerability established in the cartography*. In other words, there is a “feedback loop” (Hacking, 1995) between these categories which are refined in ethnographic practice and used in the social work that revolves around the clinic. What this circulation of meaning and sociality does in practice is to create an extraordinarily elegant resolution to that “most embarrassing question” of *just who* can be a “prostitute”. In answer to the question: “Who is a clandestine prostitute?” The clinic replies: “a clandestine prostitute is a woman who conforms to our empirically and inductively derived categories of vulnerability”. And of course, these categories are self-validating, as social workers then actively recruit women according to these categories and “sell” the programme in these terms. In these micro-interactions we can see – just as we will see in the next chapter at the Institute of Social Hygiene – that these are not disciplining relationships producing “docile bodies” but relationships full of the care and the pleasure of being recognised as conforming to a particular gendered social identity.

Technologies of gender and the *clandestine* in the clinic

Coming up hard in the field against a series of ideas I had last seen printed on a flipchart made me think carefully about the circulation of meaning, the definition and testing of empirically derived categorisations in the field, and how this process might be theorised – with the role of the clinic (machine agency) and women’s own ontological desires fully represented. Is it possible to trace the relationship between “technologies of gender” (De Laurentis, 1987), the processes that make up a “subject constituted in gender … not by sexual difference alone, but rather across languages and cultural representations; a subject en-gendered in the experiencing of race and class” (2), and other

²² The use of the French term in this case may be evasive as *caga*, the contemporary Wolof word for prostitute has the original and now largely forgotten meaning of widow (Dial, 2008). This linguistic slippage reflects the sexual danger posed by “unattached women”.

kinds of technology: a particular information aesthetic associated with NGO research work which draws heavily on ethnographic/action research?

Feminists have long argued that the body is a “medium of culture” (Bordo, 1993) .Women in Senegal have “negotiated patriarchal regulations of the body .. through aesthetic cultivation of the body” (Mustafa, 2006: 28) making “technologies of gender” to do with adornment and the identification with specific feminine archetypes and norms both an important space for the fashioning of distinctive selves *and* – in economically straightened circumstances – a visual language which inspires confidence and which might engender the kinds of trusting female intimacies which pay cash dividends in money borrowed and gifted. Dressing in a certain way, presenting a particular kind of feminine self, these are not trivial or self-absorbed activities but an outward-oriented practice which embodies an ethic of feminine solidarity. As Beth Buggenhagen notes, commodities (and for women, displaying jewelry, handbags, and clothes is the most public and obvious form of consumption) “are important social media that Muridiyya and especially Wolof use to develop social relations” (Buggenhagen, 2004). The cultivation of an idealised feminine identity is a public performance of private wealth.

What I am interested in is where these social tactics tangle with the mobile clinic project and the social workers production of behavioural ethnographies. I will think here about the possibilities of maintaining *intelligibility* as a woman (Butler, 1990), in a context where the means and modes of that positioning might let you down – might expose you to certain kinds of social risk. Taking a view informed by cyborg anthropology I draw the mobile clinic back in to the discussion below – not exempting its agency from the highly complex nexus of femininity, class, money and morals that circulates within this programme.

Fluidity, Becoming and Identity: Making the clinic the “perfect” tool for the job

So what is useful about thinking “with” the clinic, its machine agency, and its ambivalent moral status in this context? To briefly play with normative judgments, thinking *with* the clinic suggests to me two possible analytic outcomes. The first is broadly positive: the clinic might be framed as a “liberatory” technology. Consider, for example, how the clinic is embedded in a programme which *goes to* the women, which responds to the women’s own needs for health care and information, and which – crucially – does not require women to inscribe their social and sexual practices within

the legal parameters of “prostitution”. From this point of view the clinic would appear to be an exemplary tool for disrupting boundaries between public and private spaces: by turning the street into a space for consultation; between formal and informal practice; by negotiating the tolerance of illegal practices; and moral/immoral identities: by entering into partnerships which essentially reward state sanitary structures for not stigmatising commercial sex workers. Perhaps this is the kind of intervention of which Nina Lykke spoke when she discussed the importance of cyborgs and goddesses as critical figures in thinking feminism and technology:

“What concerns me is whether or not it is possible to articulate a third subject position which includes the cyborg as well as the goddess, and which makes it possible to trace subversive trends within the semiotic-material world of high-tech science and, at the same time, find them in quite different knowledge systems, world-views and productive practices” (Lykke, 1997, p. 19)

Women can access high quality health interventions with minimal disruption to their private sexual and affective projects. Indeed, the testimony they have given to the doctors and social workers who work around the clinic appears to have fundamentally changed those professionals ideas of who a “prostitute” *can be*. Perhaps the fluidity and flexibility of the mobile clinic and its “light-touch” bureaucracy reflects a movement towards enabling “permanently partial identities and contradictory standpoints”(Haraway, 1991, p. 154). Remember how the most profound experience that was reflected in the oral history interviews was the powerful *discovery* by professionals of the *diversity* of women who practice commercial sexualities: “women who during the day are mothers”, and their very real shock at the *success* these women have in holding their different social identities together. Perhaps these are forms of practice which allow for the kind of affirmative acknowledgement that Braidotti writes of sexual difference theory: “it expresses women’s ontological desire, women’s structural need to posit themselves as feminine subjects, that is to say, not as disembodied entities but rather as corporeal and consequently sexed beings” (Braidotti, 2003, pp. 43-44).

However, there does seem to be a certain technoscientific irony about the deployment of the fluid and flexible clinic and the particular kind of “fixing” that I have argued that it does on young women’s identities, locking certain culturally intelligible gestures and modes of dress into its evolving taxonomy of *clandestinité*. The particular “information aesthetic” of NGO research that I

examined in chapter four makes intelligible and makes *matter* a range of gestures, postures, adornments and embodiments. As Gillian Rose glossing Elizabeth Grosz puts it: “Bodies ingest culture to make themselves and culture thus becomes corporeal” (Rose, 2003 p. 56). Devising methods of reading corporeal culture reroutes this dense meaning back into signification, back into signifying *discourse*.

Hiding? The social and moral authority of “women who go out at night”

“In order to understand the developer’s tragedy, we must judge his vision of the world not only by what it sees – by the immense new horizons it opens up for mankind – but also by what it does not see: what human realities it refuses to look at, what potentialities it cannot bear to face” (Berman, 1983, p. 68)

Aminata Sow Fall’s satirical novel *La Greve des Battus* (The Beggars’ Strike) examines the “disappearing” of Dakar’s itinerant beggars, the *decombremment humaines* (human waste), through “beautifying” urban schemes. The novel contrasts this policy with an African ethic of reciprocity. One of the beggars, Lolli, persuades the beggars to agree to leave the city understanding that without their public presence the people of the city will struggle to meet their religious obligation to give a certain amount of money and food away every day. Lolli argues that “the contract that links every individual to society can be summed up in the words: giving and receiving. Well then, don’t they, the poor, give their blessings, their prayers and their good wishes? (Fall, [1979] 2003). The novel ends with the humiliation of the ambitious Minister of Public Hygiene when the people of Dakar insist that the beggars return to take up their position in the social order.

One of the aspects of clinic work which tends to be the most difficult for outsiders to grasp is the extent to which the aspects of the clinic *cannot go unnoticed*. The clinic’s activities are remarked upon, people do query the work that the clinic do, and according to the doctors in most places it is not too difficult to make the connection between the women who are waiting to be consulted and the purpose of biomedical intervention [*kii ay caga*]. There have been instances in which the clinic was threatened with expulsion and violence and where members of the community told clinic workers they would not tolerate those services here. Dr Ly remembered that they had been threatened in a few neighbourhoods for encouraging prostitution, or even for being pimps.

However, this has only happened a handful of times and in one instance, which Dr Ndiaye and Mamadou recalled together, the women challenged their attackers and asserted their right to try and treat themselves and take care of their health, (*nu ñakk ndoole, nun ngiy faju*). In fact, on this occasion the group leader called Mamadou after an interval to tell him that the situation was resolved and that they could bring the clinic back to where it had been parked and resume the consultation. Mamadou said that the women attacked the men on the streets who were harassing them saying: “*nu xam na leen, fii les gens se connaissent*” [We know them! Here people *know each other*].

Afterwards I asked Mamadou to explain this element of clinic work about which many of the staff at Enda were reluctant to speak, preferring to use the official discourses of stigma, shame, and the women as victims of pernicious and hypocritical moral blame at the hands of the communities where they lived. We spoke for a while about the *impossibility of knowledge* a persistent “folk” theme in Senegalese bureaucratic cultures which is the flipside to the “professional” practice of social science or organised knowing. The humility of acknowledging the limits to or the impossibility of an individual’s knowledge – and norms of discretion [*sutura*] and modest speech and behaviour [*kersa*] which mitigate against the sharing and validating that knowledge with others – is a common theme in people’s conduct, conversations and explanations about social phenomena. After we had spoken for a while about this I asked him more directly: *why – if people in very close knit urban communities know that women are engaged in some form of sex selling – are the punishments or the risks of social opprobrium not greater?*

In response he told me a story about a village which was choosing a new Imam, a candidate for the post must be of an unimpeachable moral probity. Various younger candidates put themselves forward and were laughed off the stage, everybody knew that “Moussa” smoked cigarettes; it was an open secret that “Cheikh” drank alcohol. Finally after almost all the candidates had been rejected an old man, the most respected and most venerable in the village, stood up and put forward the case for his candidacy which all the men found very convincing. However, just at that moment an old woman, her back bent, walking with the aid of stick, passed by; “Who is that speaking?”, she asked. “Alioune Niang”, came the reply. The old woman shook her head and called out: “Alioune Niang, *Waccal*”, (get down”).

The joke is of course that once, long ago, these two people were involved in a clandestine sexual relationship – there is a shared knowledge about the social and sexual conduct of men over which women hold a degree of control. This anecdote points towards an interesting story which does not appear in the official accounting of the project – the extent to which working class women’s sexualities are tacitly tolerated in urban communities. The “official” narrative which deals with marginalization, stigma and overt violence to the exclusion of other more nuanced readings of community relations, reiterates the assumption that “marginal places” are where the violence and repression of women takes place. Matthew Gandy writes that the literature on “networks and the paradoxical enhancement of spatial propinquity tends to overlook the marginal spaces where unequal power relations, violence and social exclusion are most powerfully manifested” (Gandy, 2005, p. 35). Gandy is arguing that urban theorists have a tendency to over emphasize the thickening of social relations at “novel” scales at the expense of thinking about “local” violence and exclusion. This story, however, and the many stories of women who use the clinic despite the fact that being identified as a “client” of this service risks them to violence and to stigmatization, underlines the extent to which the shared, bounded spaces within a city can result in positive and bonded proximate relationships in which a series of boundary identities and illicit practices around “being out at night” are shared between a community of people.

Two non-pessimistic perspectives on urban socialities might help to illuminate this point further. AbdouMaliq Simone and his ethnographies of urban Africa stresses contingency, coming-together and creativity, building texts full of what Rosalind Fredericks calls a distinctively “Simone-ian sense of possibility” (Fredericks, 2009 p. x). Using a similar methodology the geographer Nigel Thrift writes of the radical potential of the enforced intense social intimacy of the city (Thrift, 2005). He writes that empathy between urban dwellers might arise not as an organic emotion, but as a “social and aesthetic technology of belonging to a situation” (144).

I do not wish to overly romanticize the reciprocal ethic of *teranga* – a practice which many Dakarois complain imposes an impossible burden upon them and their families. However, I would like to briefly draw attention to the ways in which the stories told above might open up an extremely obnoxious “black box” in the study of female commercial sexuality in Africa – *respectability*. That norms of respectability are *always* violated by women seeking commercial

intimacy is not a proposition that is backed up by the anthropological literature I explored in the previous chapter. The modernity of the urban environment suggests that the city contains “multiple mores generated by differences in social position and interest” (Helle-Valle, 1999, p. 374) and that these differences cannot be read off from any general understanding of women’s characteristics. Exploring the sexual worlds of “prostitutes” and how they understand, resist and rework notions of “respectability” unfortunately lies beyond the scope of this thesis. However, here I draw attention to the silences and lacunae in NGO discourse, a reluctance to engage with the complexity of sexual mores beyond a vocabulary of shame and stigma. This is a point at which it is clear to see that NGO ethnography, although scrupulously inductive and grounded in the city, must filter its findings through a particular understanding of cultural difference.

The end of the mobile clinic programme in Dakar

When I was last in Dakar the mobile clinic programme was coming to a rather sloppy and undignified end. Red Cross funding for the work in Dakar had dried up and senior project workers were seconded to Family Health International to build up partnerships with organizations interested in using the mobile clinic for alternative purposes. For these pragmatic reasons the mandate and focus of the mobile clinic was changing and beginning to draw in the “general public” and to build in a far more formal emphasis on family planning. The reason that was given for this dilution of a model that had been specifically designed for commercial sex workers and had functioned very successfully was that opening the clinic to a wider population would avoid stigmatizing its “clients”. However, there are alternative explanations.

The end of the project work in Dakar is partly due to the increased autonomy of the groups of clandestine sex workers that Enda have established, provided resources, and have encouraged towards independence. It is also related however to the complex micro politics of inter-association and NGO interactions in the city. Working with prostitutes in Dakar, Daouda Diouf suggested to me, entailed too much competition: “And I am not interested in competing, I am interested in doing *cutting edge work*”. In practical terms the end of the Croix-Rouge funding meant that the money that had been used to troubleshoot clinic mechanical problems and to try to solve women’s day to day problems was not there anymore and this had a knock-on effect on morale and trust around the project. The clinic stayed parked at the office and the fieldworkers felt increasingly

frustrated and “out of the loop”. They vented these frustrations on the people who had taken the brunt of the exhaustion and burn out before: the office staff. “What do we do as an organization?” Mariama asked me, “If we do not help the beneficiaries? People are calling all the time – one woman in one of my groups is seriously ill, I pulled some strings to get her to see an appointment with a doctor, now she has a prescription for 16,000 CFA. I carry the prescription round in my handbag, thinking maybe I’ll find some money from somewhere. I call Enda every day to ask if there is some money there, everyday nothing”. Exhausted by the desperate woman’s calls Mariama finally asked her to stop calling. The story of the *ordonaanse* illustrates how quickly the system of trust can break down when small amounts of cash are not there to cushion crises.

While I was in Dakar in the summer of 2010 it was extremely hard to get hold of the fieldworkers, they were often out of town looking for the other “small jobs” that they do – trying to get hold of temporary research contracts, short-term photography assignments – or simply unsure of where they would be to arrange a meeting. They hid their own increasingly precarious financial situation from the sex workers who are constantly asking what will happen with the clinic, if they can get hold of money for prescriptions, where they can go for a doctor’s appointment. Visiting Mariama at home she told me that a sex worker had dropped by to talk through her problems. “I had to laugh”, she said grimly, gesturing around her bedroom: her jewelry, a lot of her clothes, and her television are missing, sold to try to pay for the gas, electricity, food for the five families who live in the rooms off the compound.

Conclusion: An ironic dream of nomads in the clinic

Three themes lie across this chapter and have shaped my analysis of the mobile clinic. The first is a study of *becoming formal*. Rather than seeing “formality” as a space or a mode of being, I have discussed it is an open ended and pragmatic process. Here I have drawn out the ways in which the mobile clinic redraws boundaries and re-works – through highly particular kinds of practice – the parameters of the informal. “Formality” is negotiated, not in relation to the state – although the NGO has fought for the state’s negotiated tolerance – but in relation to a set of norms and instruments embedded in social development which aims to work upon women’s social and human capital. This account has drawn attention to the relative *plasticity* of the state when it

operates at the borders and boundaries of its own competence, and when it transacts with “trusted” mediators.

This chapter has examined the *content* and the *consequences* of lay ethnographers’ “emotional labour” (Hochschild, 1983). I analysed a single the affective textures of a single intervention – trying to think about the exchanges of knowledge, feeling and meaning within this interaction. When fieldworker/researchers mobilise embodied knowledge, instinctively reading women’s tone of voice, dress, and gait against the criteria they generate in their reflexive and evolving research project, they are audiences to women’s carefully constructed gendered performances. These performances are then translated into research which feeds into the opening and closing of a bureaucratic category: the *clandestine*. If affect is everything that exists outside of social signification (Massumi, 1996), then the close examination of microrelationships and the objectification and instrumentalisation of this knowledge is key to understanding how African engaged ethnographers write the city, and how emotional relationships are therefore implicated in the reproduction and circulation of powerful knowledges about commercial sexuality.

Finally, running through both of these strands of analysis is a concern with the relative intransigence of the data and identification that the clinic produces. There is a tension in practice between handling women’s desire for recognition within the grid of acceptable femininities and understanding the role that the mobile clinic plays in reshaping and framing that grid by imposing a new identity upon them: client of the mobile clinic/*clandestine*. Using feminist philosophies of becoming and drawing in particular on Rosi Braidotti and Clare Colebrook’s interventions in Deleuzian feminism, I think about the worlds of women who would indubitably rather be Goddesses than Cyborgs; that is, they would prefer to elude technologically-enabled categorization of their sexual practices, but would seek to be recognized as sophisticated, sexually aware women within the matrix of sexual and social meaning which produces complex and relational archetypes such as the *janq* the *disquette* and the *diriyanke*. I followed Haraway’s “ironic dream” to produce an ironic vision of nomads in the global economy – a vision which was alive to the essential and foundational paradoxes such as the “fluidity” of the clinic, and the rigidity of the categorisation it produces. A “cyborg” approach to this case draws out the moral ambivalence of the mobile clinic as a complex social object.

As Braidotti writes about the figure of the nomad:

“The difference in degrees, types, kinds and modes of mobility, restlessness, exile and nomadism need to be mapped out with precision and sensitivity. This cartographic accuracy is made necessary by the fact that nomadism is precisely not a universal metaphor, but rather a generic term of indexation for qualitatively different degrees of access and entitlement to socially empowering (or not) subject positions in an historical era for people who are situated in one of the many poly-located centres which weave together the global economy” (2003, 56).

The final irony about the employment of *image* of the fleet and mobile nomad connects to the *literal* reality of the spatial work of the clinic. I observed how the clinic, when entering a neighbourhood, is often penetrating a space which for “women who go out at night” is a locality of shared meaning, social protection, and mutualised social jeopardy. Interrogating the assumption that women *must* present a single image of “respectability” in order to live a life free from the threat of violence shows that – sometimes – the possibility for an “affirmative mode of becoming” (Braidotti, 2003) lies closest to home.

To conclude this chapter I note – without comment – that the mobile clinic has a clear commitment to close ethnographic work, strong relationships with the women who participate, clear political ends that it pursues (lobbying to change the national law), and an uncontestedly innovative use of a piece of technology to underpin a *novel* identity which has a (de facto) legal status, and which has re-written assumptions about the distribution of Senegal’s epidemic. The mobile clinic can therefore be considered an *exemplary* intervention in cyborg anthropology.

CHAPTER SIX: MOLECULAR AND MUNICIPAL POLITICS: TRACING REGULATION AND EXPERIMENT AT THE INSTITUTE OF SOCIAL HYGIENE

In the opening chapter I reflected on my first experiences of visiting the Institute of Social Hygiene and realizing that the official sex workers registered at the Institute of Social Hygiene had been enrolled in longitudinal research projects and the records held by the state detailing the women's personal and medical details thus "constitute[d] official rosters from which prostitutes could be accessed for research purposes" (do Espirito Santo & Etheredge, 2004, p. 138). These experiences galvanized and synthesized a series of reflections about the changing histories of regulation and intervention that flowed through the clinic. On one side of the clinic, state social workers (here Mme Faye and Mme Niang), *sage femmes* and nurses registered new women, dealt with the police, and made sure that women fulfilled the legal obligations attached to registration. On the other side of the clinic, two doctors (here Dr Diouf and Dr Diallo) employed by a biomedical research team provided high quality medical care and coordinated a longitudinal cohort study.

I went to the state clinic to study sanitary "regulation", the patching together of different policing, data gathering, and care practices to classify and work upon poor women's sexual behaviour. I found myself studying the complex relationship between state sanitary regulation and experimental science. How was biomedical research work integrated into this highly specific social and clinical space? How do the practices associated with biomedical research "spill out into mundane medical environments" (Petryna, 2007a, p. 290)? What happens in these complex spaces in which care, state bureaucracy, and biomedical research are shuffled into one another? What *difference* does experimental science make?



Figure 10 The clinic in the city: The Institute of Social Hygiene, July 2011 (Photograph: Poleykett)

The experience of visiting the Institute of Social Hygiene pushed me towards case study data. Getting to grips with ethnography and analysis at the site, however, disrupted some of my assumptions about the space-time of the clinic and the changes that had taken place there. In carrying out the ethnography it became clear that, however tempting this analysis might be, the site was not a “palimpsest” “in which layers of history simply overlie and partly obscure and erase ones that went before” (Massey 2008 cited in Dave, 2011). The continual transgression in the clinic, between its long colonial and postcolonial history and the integration of the Natural History trial, and between the conflicting mandates: therapeutic, experimental, and bureaucratic, are embedded in the clinic’s everyday practices and are productive of new bodies, new understandings, and new differences. In this chapter I tie my ethnographic analysis of experimental and regulatory work at

the clinic to my interest in “the body as a space of scientific endeavour” (Livingstone, 2004, p. 73). What social bodies are made-up by these hybrid forms of regulatory and experimental practice and what differences are implicated and produced at this site?

Sites of medical research and medical practice

Moving around the clinic I felt as Alice Street describes her first trips to the Papua New Guinea clinic: “It was hard to imagine that the crowded and busy clinical space for the ward was in fact a complex experimental system that had been designed to yield uncompromising facts about drug-disease interfaces in tropical countries” (Street, 2009). Conducting ethnographic fieldwork and oral history interviews, however, with social workers and research doctors I began to see how far these two functions overlapped in practice. Geographers of health and biomedicine are increasingly interested these spaces with dual experimental and clinical identities (Greenhough, 2010b). Greenhough proposes that approaches from geographies of science should be combined with “therapeutic landscapes” (*ibid*). In this chapter I consider some of the changes that have taken place at the clinic as state sanitary regulation is influenced by and practiced through biomedical research. I discuss the strategic leveraging of resources for research which helped to build capacity and to begin the process of making state regulation congruent with research objectives. I then pay close attention to the banal bureaucratic practices that pre-date the arrival of biomedical research, but which also shift to accommodate research work and help to arrange and assemble the research subjects. I then examine the changes that have taken place at the clinic – the proliferation and alliances and the thickening of connectivity, a *traffic* between different actors which produces social relations based on consent and pleasure as well as on coercion and police work. Here I focus on how the forms of political organisation and social solidarity engaged by registered women have helped to create, contour, and sustain an experimental cohort. Finally, I consider what kinds of ideas about experimental spaces might be read in the collaborative care work undertaken by state social workers and research scientists.

The descriptive and ethnographic approach that I take in this chapter rooted in daily practice at the clinic serves to expand the focus of analysis beyond biopower as the normalisation of life through the control of human populations, and towards intertwining logics, rationalities,

technologies, and techniques of care that produce ambivalent and not always directly “disciplining” outcomes.

Unnatural Histories: Regulation at the clinic the arrival of the Harvard Team

The background of the research at the state clinic is the discovery of HIV-2 in Senegal. In 1984 a Senegalese research scientist, Professor Souleymane Mboup, began to draw blood from hospital patients and registered sex workers looking for a reservoir of HIV in these populations. One of these blood samples which he sent to colleagues in Harvard for testing was found to be infected with a distinct type of HIV virus, eventually designated HIV-2. In 1985 an Inter-University Convention was signed between Harvard, the Université Cheikh Anta Diop in Dakar, and the Universities of Tours and Limoges in France. This collaboration resulted in the Natural History of HIV-2; one of the longest studies of HIV infected people in the world, and a considerable transfer of expertise, personnel, and laboratory equipment between Boston and Souleymane Mboup’s laboratory at Dantec hospital in Dakar. The Natural History Project was carried out amongst the population of official sex workers registered at Dakar’s state clinic, a population that had long been seen as a “gold mine” for scientific research (Gilbert, 2010).

Natural history studies of HIV map the “natural” (unimpeded by use of drugs to arrest the multiplication of the virus) course of disease from the point of infection, moving through diagnostic stages, and eventually to death. The Senegalese Natural History project, subtitled the “Prostitute Project” mapped the epidemiology and infectivity across 10 different genetic human immunodeficiency virus type 1 HIV-1 subtypes, and compares HIV-1 subtypes to HIV-2 subtypes (Kanki et al, 1999). There have been few successful natural history studies conducted in Africa. Natural history studies require large numbers of people to consent to regular testing over a long period of time, usually longer than ten years (Jaffar et al, 2004). However, when natural history data is verified, it can correct widespread misapprehensions about the epidemiological specificity of the African epidemic, and can be an invaluable tool in planning and executing prevention programmes (Morgan and Whitworth, 2001).

As I will explore further in this chapter there are several reasons why the state clinic presented such “ideal” conditions for biomedical research and why the Natural History trial in Dakar was successful where others on the African continent have failed to retain participants. First, the

registered women are comfortable with giving data. For example, Gilbert *et al* (2003) note that “HIV-1 and HIV-2 serostatus data at each clinic visit were available from all sex workers. Information on nationality, age, date of cohort entry, and years of registered prostitution were available from greater than 99% of the sex workers”. Second, HIV-2 – “the world’s other HIV virus” (Gilbert, 2010, p. 41) has a distinctive epidemiology. The interval between infection with HIV-2 and death is significantly longer than in HIV-1 infected individuals HIV-2 produces more “long-term nonprogressors”. This makes a cohort including some HIV-2 infected individuals a significant resource as “if scientists can unlock the mechanisms that allows these individuals to achieve viral control, it could represent a major step forward in the development of an HIV vaccine” (Gilbert, 2010, p. 29). A social and historical quirk – the retaining and elaboration of postcolonial regulation had serendipitously produced a population well-schooled in “trial-work”. As Souleymane Mboup said when we talked about this: “It was almost too perfect! It’s like we were dreaming.. like we dreamt what we had to do, so that when the opportunities came, we were ready to take them” [Interview, SM]. This discourse of a very serendipitous set of events that unfolded almost independently of any action or intervention is a quite common one I suppose – as is not entirely disingenuous, that is how it feels I think for these senior scientists. Moreover, the *bodies* that regulatory policy *made bio-available* were not simply “commensurate” [that is, they could *stand in for* other less *accessible* bodies in other, more regulated clinical spaces]; they actually represented an opportunity to go beyond HIV science in the developed world. This opportunity has two dimensions and they are both related to the so-called “missed opportunity” in the US and Europe, when effective drugs became available before the scientific value of studying the virus both “in the wild”, and in *relation to drugs* had become apparent (Crane, 2007 pp. 189-190). The distinctiveness of this population – then – existed on two levels: the *molecular and the municipal*.

The collaboration with Harvard and the Natural History of HIV-2 project came to an end in 2001 and the Senegalese team were placed in an invidious position. They were the custodians of a serological archive which could continue to be of paramount scientific importance but which they could not guarantee a continuity of funds to preserve. They also had developed trusting relationships with the official sex workers at the clinic which they were not prepared to terminate. The state clinic could not simply shift back to the “old” system under which women’s care was

overseen by the nurses and social workers, but the resources of the state could not sustain the laboratory network and pay the salaries of the doctors who had been employed directly by the Natural History project. The commitment that they had made to distribute the social good of biomedical research through high quality care and trusting personal relationships had to be honoured, but how? The team applied and won funding under the CIPRA programme (the Comprehensive International Programme of Research on AIDS). Under the current arrangements the doctors salaries are paid by CIPRA, this allows them to continue to do their work and continue to play the crucial role of mediators between the clinic and the laboratory. The ongoing struggle to secure sustainable funding which can preserve the integrity of the links between field, laboratory, clinic, and the humanitarian works on the fringes of the clinic (Association AWA for example benefit financially from research work and Souleymane Mboup and his associate Aziz Hane sit on the board for AWA), as well as continue to develop in-country expertise is difficult and stressful work.²³

Regulation at the IHS: Continuities and care since 1984

As I discussed in the introductory chapter, the legal and medical arrangements for the regulation of official sex work in Senegal have their roots in post-war France and in a series of acts promulgated simultaneously in the metropole and in France's West African colonies. The Senegalese state clinic is still housed in the late colonial hospital, a dilapidated but still strikingly beautiful building built in the "Sahelian" style which became fashionable after interest was sparked by the African pavilion at the colonial exposition in Marseilles in 1931. Thomas Shaw's study (2006) traces the peculiar combination of genuine admiration, artifice and expediency which influenced the French adoption of the Islamic influenced adobe architecture of the Sahel. After Fashoda and World War One the French authorities in Dakar moved to build an "imperial city", stung by allegations that the capital of French West Africa resembled a "dismal provincial town" (Betts, 1985). As Raymond Betts argues, architecture in Dakar was never neutral: 'Because Dakar became the major city of Senegal, the colony in which the doctrine of assimilation was given its

²³ Mboup's Dantec laboratory has been exceptionally successful at training young Senegalese scientists and moving them around for stages from Harvard to other countries in West Africa. The alumni of the laboratory now run a range of successful private laboratories around the city, such as Bio 24 where I went to get fast and accurate malaria testing, servicing private hospitals and clinics and providing newer services such as paternity testing.

greatest publicity and most intensive practice, urban development, both spatial and social, was closely regarded and criticized' (193). In the final decade of French rule the colonial authorities imported the West African vernacular style filtered through the imaginations of the curators of the colonial expositionsⁱ, and built three buildings in the Sahelian style: the cathedral, the maternity hospital, and the polyclinic (IHS). Of the three, the polyclinic is probably the most impressive, and the most superficially "authentic"; as Thomas Shaw points out, the buttery terra cotta of the low exterior walls does resemble mud.

Post-independence in 1960 some of the zeal with which the colonial authorities had executed the regulatory programme ebbed away. However, interest in regulation remained and the law on prostitution was re-codified in 1969. This postcolonial law drew heavily on the colonial legal framework (Becker & Collignon, 1999), but also on the experiences of clinic staff who had visited urban health centres in Washington and Baltimore [Interview, Ibra Ndoye]. The 1969 law reiterates some of the discursive emphasis on "equilibrium" so evident in sanitary statism – the emphasis is placed upon individual state employees to judiciously balance the "social" and the "medical". The law argues that medical and legal authorities should always weigh the *health* costs against any moral or social benefit that might be involved in the policing of prostitution. As such, the 1969 law does not represent a break with the colonial "sanitation syndrome" (Swanson, 1977) that had characterized colonial regulation.

During the 1970s Souleymane Mboup – then a young research scientist who had only just defended his doctorate – began to conduct biomedical research with women registered at the state clinic. He conducted several relatively informal studies into the prevalence of chlamydia among the women: "we were just doing it out of academic interest really, there was no large-scale work" [Interview, SM]. During this time, however, Mboup and Ndoye were laying the groundwork and building up the relationships that would allow them to eventually base themselves at the Institute of Social Hygiene.

The next development was the launch of a major USAID-funded family planning programme in Senegal. Mboup and Ndoye working with other young Senegalese scientists and clinicians were determined to leverage some of this funding to put towards their burgeoning research programme

into sexually transmitted infections. “We wanted a programme in which we were able to develop some extra expertise in certain aspects of women’s general health”, Professor Mboup explained. “We argued that to run a Family Planning programme, well, there are certain kinds of contraceptives for which in order to prescribe them you have to know a lot about the health of the woman standing in front of you – we said that we wanted to know more about certain STIs”. The negotiation was not straightforward as USAID²⁴ wanted to focus closely on providing the maximum coverage of contraception and family planning advice possible, not to invest in the development of scientific infrastructure in Dakar. However, eventually USAID agreed that they would establish several laboratories in Dakar so that the Senegalese team could monitor the general population “in order to have a general picture of the overall level of STI infection among certain populations” [Interview, SM].

In 1984 when the Natural History Project was launched two doctors were “implanted” at the clinic to enhance the care provided to registered women and to oversee the enrolment and collection of data for the research programme. The trial doctors arrived at the site in 1986 and have been continuously employed there since then.

This long prehistory of speculative and open-ended research projects at the Institute of Social Hygiene leads Dr Ibra Ndoye – head of the state clinic in the late 1970s and now coordinator of the CNLS – to stress *deep continuities* in care, research, and intervention at the state clinic. He attributes these continuities to the long-standing interest in women as a research population which led to a continuous mixing of the “sanitary and the biological” from the immediate post-independence period onwards: “In the intervention there was always a mix of the sanitary and biological – because we tested [registered women], practically for free” [Interview, IN]. Throughout this chapter I try to reflect on change and continuity at the site, juggling the perspectives of some: “Nothing has changed”, with others: “Before we arrived here there was practically nothing”. What is clear is that there was a significant “archive of practice” at the site as this fieldnote on testing at the clinic illustrates.

²⁴ Senegalese researcher and health campaigner Pape Amadou Gaye notes that there is an “untold story” about the impact that USAID had on family planning in Francophone West Africa in the 1980s. In the following decade, however, it disinvested from family planning <http://www.ministerial-leadership.org/blog/gaye-family-planning-bargain-when-it-comes-investments-health>.

“At the polyclinic the oral interviews that I conducted with the doctors stressed the changes that had taken place over the last twenty years (since the discovery of HIV-2 and the integration of biomedical trials into the site). The doctors were adamant that the site had been thoroughly “ethicised” in line with the international protocols governing conduct in spaces associated with HIV and more specifically with the international and local protocols relating to ethical behaviour in biomedical trials. Every HIV test carried out at the site – the doctors maintained – was carried out strictly in accordance with the sacrosanct principles of informed consent. However, there *was*, Dr M. remembered, a compulsory blood sample taken from all women who signed up at the clinic. The reason for this is that the compulsory blood test for syphilis predates the arrival of HIV, and the transformation of the care system that the virus engendered, and has remained “on the books”, part of the practiced series of gestures that make up the process of inducting women into the clinic. Within the range of compulsory and non-compulsory local care directives, it was almost impossible for women arriving to register to disentangle the testing which guaranteed their care and the testing which was part of an external and little understood research regime” (IHS Fieldnote June 2009)

The archive of practice is made up of a series of obdurate gestures, difficult to dislodge.

Registration

From the beginning of the Natural History trial until 1994 the research team had no clear and separate consent procedure for enrolling women – the research piggybacked on the registration and documentation procedures used by the social workers. Since 1994 consent procedures have changed and the doctors handle the enrolment procedure and are responsible for ensuring that the women are fully informed about the research work. The enrolment is thus collapsed into the therapeutic encounter and is managed partly through the close and respectful relationships that the women have with the research physicians, although the doctors are clear that they treat all women regardless of decisions they make about participation in current or future research projects.

Registration with the clinic, however, is the first point of contact between the women arriving to register and the clinic bureaucracy, and as such is a key moment in establishing a set of relationships and beginning to unpack the women’s experience, translating their lives into a set of local categories of risk. At the moment of registration women are not only a community of sex workers – a community with its own spaces, its own memories, rituals of membership and conviviality, they are also joining a pool of potential research subjects. In order to understand how the clinic became a research site and how longitudinal research has been carried out here so successfully, it is necessary to understand the circumstances of registration.

The potential social and personal cost of entering the state clinic as a registered sex worker is high. As one clinic worker puts it in Renaud's study of registered sex workers in Kaolack, Senegal: 'being a prostitute is humbling but registering is humiliating, it's like signing up to be marginalised' (Renaud, 1997, p. 145). While women are legally entitled to deregister when they are no longer selling sex²⁵, in practice women report that this process is lengthy, invasive and humiliating. Even when the women are deregistered the police keep their files open in the expectation that the women will lapse back into prostitution when their other economic activities fail (Renaud, 1997, p.146). In tightly knit communities women who have de-registered continue to experience anxiety about the security of information held at the clinics (Foley & Nguer, 2010). Moreover there is a "clear connection between a police file and a health file" (Tandia, 1998 p. 242), and some official sex workers claim that the police frequently use the information that they are required to give on registration to follow them and arrest them for soliciting (Bougazelli, 2006). Some sex workers claim to pay regular bribes to the police to avoid harassment (Foley and Nguer, 2010: 331). There is certainly a high degree of cooperation between the police and the government clinics. If an official sex worker is stopped for soliciting, the police check the date of her last clinical appointment, if she has not been examined for some time she will be detained and then escorted to the Institute of Social Hygiene. In other words, the line between licit and illicit practice is indistinct, and the police subject registered women to as much scrutiny as unregistered women. Although registration is frequently a devastating moment in a woman's life, many older women report when they arrive that they can no longer tolerate the constant stress of an itinerant, illicit lifestyle; as one registered sex worker remarked to Renaud "clandos [unregistered prostitutes] are always afraid and I am afraid of nothing. I'm regulated". (Renaud, 1997: 145).

In Lara V Marks' *Sexual Chemistry* a history of the development and trial of the oral contraceptive pill she records philanthropist and biologist Katherine McCormack's frustration at the lack of a "cage for ovulating females to be experimented with" (Marks, 2001). This problem was eventually surmounted when pill trials were carried out with residents of a female prison in Puerto Rico. For obvious reasons research subjects who have their freedom of movement legally constrained are ideal subjects for research programmes which struggle to retain participants. Once when I was

²⁵ Article 8, Décret No. 69-616 du Mai 1969 portant application de la loi no. 66-21 du 1^{er} Février 1966

chatting with Mme Faye I used the opportunity to probe a little more about consent and how women felt about the various services – do they, for example, ever resist or complain about the gynaecological examination. No, Mme Niang replied – it's in the *engagement*, they know that they have to be examined and have to be treated, we make sure that we explain it to them *properly* at the beginning to ensure there is no grounds for complaint later on. Thinking aloud I continued – “If not, I suppose, the women would just come to fulfil the obligations imposed upon them by the police”. “*That is the only reason they come*”, Mme Faye exploded in frustration, partly at my obtuse line of questioning and partly at the lackadaisical approach of the women registered at the IHS. “But”, she added, “you know that the police don't give out presents [don't go easy on anyone], they're behind them every single day”.

Nevertheless, some women stress that they *choose* both to register and to keep coming back to the clinic. “We like it here”, one woman told me, “if we didn't like it, we would all find somewhere else to go, we would all leave immediately”. If “[t]he story of healing is one of public power and private choice” (Feierman & Janzen, 1992, p. 16), then “choosing” registration reflects women's exclusion from other spaces of biomedical care in the city but also the trust that they place in the clinic staff.

When women arrive to register, alone or accompanied by the police, the social workers have to be as explicit as possible about the legal implications of registration. They are also legally required to attempt to “dissuade” women from registering, which they usually do as they conduct the initial *enquête*, or biographical interview. The responsibility to dissuade creates a dissonant and jarring moment of interaction (as can be seen from the field-note excerpted below). This element of clinic practice is a trace of institutional moralism, but which is used by the social workers to impress upon the women the seriousness of their decision to register as a prostitute across linguistic and cultural barriers to communication. This responsibility to dissuade women from registration partly explains the brusque tone of the social workers' interactions with registered women. The following exchange took place when a young Nigerian woman arrived to register at the clinic. It illustrates particular relation of care that is expressed at this juncture (Brown, 2010), and shows how the women begin to assemble their “sad story” (Agustin, 2004), countering questions and accounting for their presence at the clinic.

“Why have you left your country and come to my country?” Mme Faye deadpans in mock grievance. The girl laughs and the second social worker chips in: “Nigeria is a rich country!” “I don’t know”, the young girl replies, smiling a little uncertainly, and then adds mildly “It’s not our fault”. She has been brought to the clinic by the police with two other young Nigerian women, part of a steady flow of women from Nigeria to Dakar – so many that the social workers have picked up a rudimentary pidgin. “There are people in Nigeria who said they could take us to Europe, they deceived us”.

“You want to go to Europe!” Mme . “I will go, I will get to Europe”, she says, still smiling and with her eyes cast politely down, but quietly defiant.

“Do you know about AIDS, do you know how to protect yourself?”

“Yes”

“How do you protect yourself?”

“I use a condom”

“Every time?”

“Yes, every time”

“Do you have boyfriend, a nice Senegalese boyfriend? I can find you a nice Senegalese boyfriend”

“No”, she laughs, “I don’t want one, I don’t want to get pregnant”, she mimes the curve of a belly with her hand.

“Is your mother in life?” “Is your father in life?” She has one five year old son, left with her mother in Nigeria. The social worker takes her mother and her father’s names. The young woman watches anxiously as she fills one sheet with close, cramped notes and flips to the next page.

“This”, she says, pointing at the fiche in front of her on the table, “this is to be a prostitute, you understand that?” She nods. “Why are you doing this?”

“I don’t know”

“Can’t you do anything else? If you go to Europe what will you do there?”

“Hairdressing”

“Hairdressing, is that all you know how to do?”

“Yes”

For this young Nigerian woman registration was way of easing some of the pressures of working and seeking healthcare in a strange city, a city in which she has no intention of remaining. For other women registration is a calamitous life event, a decision only taken under intense and unbearable pressure. I was present at the registration of a Senegalese woman in her fifties. On the day of her registration she arrived at the clinic at 6am, partly to slip out of her neighbourhood avoiding awkward questions and partly because the functioning of the clinic was, to her, entirely opaque and she wanted to make sure she did everything possible to conform to the demands of registration. “I have never been here before”, she told me, rapping several times on the table to emphasize her point. “This isn’t what I want, but I’m so tired. They told me that with a *carnet* it’s easier, if you have trouble with the police you can show it to them. I have never been here before, I’m ashamed! Just give me the *carnet* and I’ll go.”

For this woman – as the social workers well know – “presenting” themselves at the clinic is one moment in larger story: the struggle to hold together families through “legitimate” work, and frequently, the loss or abandonment of the husband. As the head social worker said to me during one interview: “we try to dissuade them, to tell them that they mustn’t enter into prostitution: we tell them about the inconveniences, the risks they run – we tell them all of these things. But you know, when a prostitute presents herself here; it’s not the first time, *every prostitute who comes to sign up for the first time has been a clandestine.*” The social workers lay considerable emphasis on the « cooling off period » that they impose upon the women, this is to ensure that no coercion has taken place: “we leave it up to them, *really*, sometimes we even tell them to come back – we don’t give them the *carnet* on the same day, we say *just wait and see*, but then they come back, they say “now I’ve made up my mind”. Despite the sincerity with which the social workers want women to talk to others at the clinic, to reflect and to engage, before making the decision to sign up, the formal purpose of the consent form is to discharge the legal obligation of obtaining full consent

before performing an HIV test [*on signe un consentement pour avoir une couverture juridique, pour que quand elles ont le VIH qu'on puisse l'informer*].

The older Senegalese woman who arrived on that day was instructed to take an HIV test immediately and she nodded her consent and marked the consent form. However, there was something that she had not understood. When she was told to return a month to the day she conceded cautiously “Yes, if I have the time”. When she is told that she must continue to return otherwise her *carnet* will be taken away and she will have more problems with the police she shakes her head and clicks her tongue – she has not understood that state regulation involves repeated visits to the clinic.

Shuffling Papers: Prosaic state practice and research/regulation

The social workers’ office is tucked around the corner of the MST and dermatology block, it can be accessed by a discreet second entrance so that registered women can come to and fro without being observed. The staff at the clinic have worked hard to ensure a steady traffic of women, children and men referred for dermatological complaints, and have made sure that there is no obvious distinction between general consultations and the quiet corridor where sex worker’s care is arranged. The trial doctor who left me at the door of the social workers office – the room where the registrations take place and where women’s data is held – stepped away respectfully describing the room as the “heart” of the clinic. Filing cabinets line the walls of the room, each containing individual *fiche* filed by year of registration. The first cabinet has drawers labelled 1970-1976, the second 1978-1980, after that there is one drawer for every year, each filled with familiarly institutional-looking manila files. On the far side of the room there is a larger cabinet with three drawers labelled *raflées* [picked up by the police], *decedées* [deceased] and *perdues de vues* [lost contact]. There are three offences for which a woman can be brought to the clinic by the police: soliciting, not having a sanitary card, and not attending medical appointments.

When a woman arrives to keep her monthly appointment she pays a fee of 500 CFA for the consultation, collects her receipt, and comes to check in with the social workers. The social worker collects the woman green booklet [*carnet*], the auxiliary matches the date of registration on the

carnet to the filing cabinets, picks out the file, drops the receipt and the carnet in the file and drops it off with the nurse who will carry out whatever tests are required - a gynecological or serological examination and discuss any on-going treatment or health problems. The nurse then fills in the *fiche de consultation* which the social worker checks before stamping and dating the *carnet*. The consultations run on strict time cycles. Each woman should be consulted once a month, her first and then every other visit is a *visite complete* - with blood tests and gynecological examination. Alternate months are *visite simple*, consultations which allow the clinic staff to "check in" with the women, offer them more condoms and make sure they are taking any prescribed medicine.

The *carnet* is the proof that the women are registered and are up to date with their consultations; they are required to carry this document at all times. The social workers complain that the women often lose their *carnet*, or forget it, or pretend to have lost it so that they can claim to be up to date with their consultations when they have missed appointments. This is a real headache for the clinic because they need to match the number on the carnet with the number on the file in order to be able to pull up the women's records. In order to dissuade women from forgetting or losing their *carnet* the clinic demands a police certificate certifying the loss of the *carnet* and they charge the women 1000 CFA for a replacement. Even when the women remember the number on the *carnet* and want to be consulted they are refused. "How can we do a consultation without the carnet?" came the impatient reply when I asked why. The *carnet* is a legal document and the information it carries must correspond exactly to the care that women have received. The social workers and nurses are therefore reluctant to provide official care outside of the clinic's strict interior time cycles but they go to great lengths to support registered women and their families with health or personal crises as they arise.

The file that is held at the IHS must contain up to date information including the women's name, mobile phone number and address. It is very important, the head social worker explained, that the clinic has the exact address, because the women move around a lot and the clinic staff may need to do a home visit if they lose contact with a woman they perceive to be vulnerable for a worrying period of time. Indeed, a lot of the work that the social workers appear to do is constantly refining the address - which is by necessity descriptive as Dakar has no postal service - and checking that

the women's phone number is up to date, sometimes by putting it in to their own phones and making sure that her handset rings. When one of the women gives a number a little too quickly the social worker's suspicions are aroused. "Don't just make it up!" [*bul inventer de!*], she snaps, the woman repeats the number, slower this time. "Are you sure?" the social worker presses, until she is satisfied that the woman has given her the correct information. The social workers participate actively in preventing "loss to follow up" by impressing upon the women that they must be conscientious about meeting their appointments and by conducting - or threatening to conduct - house visits. When I mentioned to the head social worker that there was a close and mutually dependent relationship between clinic bureaucracy and the organisation of the research cohort she agreed: "It's us who have the addresses, not them". Some of the resources of the trial flowed through to the "other side" of the clinic in the form of a small amount of money, a *petite motivation*, for the clinic staff to conduct home visits which the social workers very much enjoy as it allows them to get out into the city and be part of a more "hands-on" intervention. While this is not provided for under the resource allocation or within the remit of the state clinic, the social workers have used the research resources to explore creative work beyond their job descriptions and beyond the humdrum work of registering women and stamping their *carnet*.

The file is also significant because the double will be held simultaneously at the police station. The social worker frames this as a bureaucratic means of double-checking identities, for example, when a registered woman has her card retained for any reason, her status as a registered prostitute and her "existence" in the clinic's roster can be quickly confirmed with the police by checking the woman's identity card against the data gathered during the biographical *enquête*. This system has functioned extremely well in the forty or so years since the legal status of prostitution was clarified and codified - the social workers keep a copy of the legislation filed at the clinic and referred me to it for the finer legal points. However, strict adherence to the rules at the clinic can be finessed at certain junctures. For example, one of the rumours which acts to powerfully dissuade women from registering is that, strictly speaking, once women have registered at the clinic they are then banned from marrying a member of the armed or civil service. The Senegalese military make up a large number of the women's clients and removing the *possibility* of finding a good husband and a legitimate social identity through marriage is an idea which many women resist. However, as Mme

Faye told me one of “their” women had married a man at the heart of state power – a bodyguard in ex-President Abdou Diouf’s retinue. “You see”, she said ironically, “everything can be arranged in Dakar” [*tout s’arrange à Dakar*]. The fact that women are deterred from registering for these reasons, however, indexes some of the *pleasure* that comes from legitimacy, from participating in clearly defined rituals of citizenship based on a guaranteed reciprocity – the exchange of certain autonomies for legal status. This demonstrates another aspect of the clinic and its bureaucratic order; that order is tied to the “social density of citizenship at the scale of a legitimate linkage to the reciprocal social world” (Berlant, 2007, p. 284). This is a kind of affect and pleasure which cannot be underestimated for poor and marginalised women whose interactions with the state in their everyday lives are so limited and so negative.

The social workers are responsible for making the bureaucracy work in practice – for ensuring that it is as responsive as it can be to the needs of women arriving exhausted and often traumatized by their experiences of *clandestinité* which may include severe health crises. They also – through their caring practices and their affective labour, and through their home visits (threatened and real) – help to create and enforce women’s loyalty to the clinic. It is not just the outreach work that the social workers conduct that links the daily practices of regulation to the work of creating and maintaining a research cohort. The social workers gather information in the form of a biographical story of risk and vulnerability which is shared with the research physicians. Second, as they carry out the routine testing and physical inspection of the women, they prepare them for the testing associated with the research. The clinical “preparation” is similar to the process that Charis Cussins in a different context calls “anticipatory socio-naturalisation” (Cussins, 1996) before the women consent to trial work they have already begun to understand the clinical itinerary upon which their care is contingent.

Lynn M. Morgan and Monica J Casper writing in another context give an example of the co-implication of state power represented by “new bureaucratic technologies” and scientific technique:

“State functionaries have recently used their power to create a new class of citizens: foetuses. They use their own “reproductive technologies” – administrative rules, laws, and judicial rulings – to elevate their status of the unborn by erecting a legislative and judicial

framework that extends the state's already significant domination over pregnant women. These new bureaucratic technologize work in tandem with the scientific and biomedical developments that make foetuses increasingly visible and accessible, and thus more available for public appropriation". (Morgan & Casper, 2004)

Paying attention to the "little things", the "numerous bureaucratic/logistical practices (which primarily shuffle paper), as opposed to theories about bureaucracy" (Thrift, 2000, p. 382), shows up scientific work in two important ways. Firstly, it shows the many different kinds of work that happen in blended spaces of scientific production. Exploring the clinical hinterland of the trial shows not only the contingent and locally embedded work of science but also the banal processes through which research subjects are assembled and prepared for trial work. The registration biographies show how experimental populations are formed when women are either compelled or *compelled to choose* registration and how this choice is negotiated at the intersection of political economies and health crises (Petryna, 2007b; Sunder Rajan, 2005). Second, this has the effect of exposing the work of largely female state employees who do the delicate and difficult work of balancing and mediating between regulation, trial work, and care. It is the activities of generally female and low paid nurses and social workers to transform women into "cooperative subjects for HIV/AIDS research" (Booth, 2004, p. 7).

Humanitarian Police Work: Association AWA and the State Clinic

The diagnosis of the first case of HIV-2 in Senegal and the establishment of a cohort trial at the Institute of Social Hygiene led to profound changes at the clinic. This diagnosis led to the arrival of a new experimental regime set up to investigate the viral specificity of the population of sex workers registered at the Institute, enhancing its laboratory capacity, working on its epistemologies of intervention, adjusting its ethical terrain, and reorganizing its maps of expertise. A second and related change that has taken place has been the creation of AWA, a radical, sex worker-run association. AWA was founded in the clinic by the social workers and a group of registered women.

In the early 1990s members of AWA began to organize themselves around the prevention and diagnosis of the new virus. They were going out into the bars and trying to solve the problem they had already diagnosed: women were resisting registration and staying away from the Institute of Social Hygiene unless they were taken there by force. The registered women adopted a different

tactic, speaking frankly and persuasively to their unregistered peers and persuading them that the many rumors which circulated about the IHS were untrue or exaggerated. One *animatrice*, referred to respectfully as a *doyenne* who had been working around the IHS for many years, reflecting on the changes at that time observed that the police would bring unregistered women to the clinic, either that or the *animatrices* would bring them [*polis moo ko indiwoon walla animatrices moo ko indi*].<#>

In the last few years AWA has moved out of the clinic into offices close by, begun to be funded by the Global Fund, and now works more widely with *femmes vulnerables*. However, AWA also maintains a very intimate and also problematic relationship with the Institute of Social Hygiene. In an interview the current director explained to me that because AWA was 'born' in the state clinic, 'we cannot go beyond the services provided by the state'. However, she qualified this, saying "but we are also an NGO, and we have a *vision*, while the state just has an approach which is purely based on public health principles".

One of the most compelling examples of how this clinic which initially seems such as quirky, such a self-contained site, is profoundly porous and open to the city is the extent to which the goodwill on which the clinic system so depends is itself dependent on AWA; the social welfare organisation with the professionalising development remit. I asked one ancienne what she thought of the clinic: she rattled through an itinerary which shows how each element of the welfare system locks together.

B: Noo gise Clinique bi?

"Baax na, même doktoor sax! Soo bookee ci AWA bi, dañuy dimbalee tammet, lepp ci fi [points to head] dañuy dimbalee, dañuy faj sa soxla, bu bindee ordonaanse bi, ku amul xaalis, dafa bind beneen feuille, bi facture la, yaa ko yobbee AWA"

She added, by way of clarification, "If it wasn't good here we would all go somewhere else, all of us, we'd leave straight away" [Su baaxul danuy dem seeti feneen, ñun yépp danuy daw...]. The *anciennes* are maternal figures and slick advocates for AWA and for the clinic. Following *les anciennes* around the clinic and observing their interactions with other women, it is clear that the links between AWA and the clinic are decisive when they are persuading young women to register,

in these interactions they specifically stress that AWA will pay their *ordonaanse* (prescriptions). Moving between the AWA offices and the Institute of Social Hygiene with women who were going to collect money for their *ordonaanse* it is clear that the functions of these two facilities are inseparable in practice. Insofar as positive consent and enthusiasm for state sanitary policy exists, it seems to me to be sustained to a large extent by the advantages associated with membership of AWA, a consent which is therefore underwritten by money from the Global Fund.

These two stories, one about the ‘warm’ feelings associated with testing and the other concerned with sex worker’s forms of organization and association illustrate further some of the complex overlapping worlds at the clinic. These are two processes which help to create, contour, and sustain the experimental cohort. Membership of AWA helps to sustain these overlapping projects, making registration and consultation more palatable for women and contributing the close and trusting relationships at the clinic. Here, paying attention to the state serves to bring into sharp focus the multiple networks of welfare that sustain, define, and delineate its practices.

The profound interpenetration of experimental and regulatory practice is not only evident in the bureaucratic confusion and in the mixing and mingling of functions which is part of the daily practice of clinic work and more generally part of pragmatically mobilizing and maximizing resources in state spaces where need constantly outstrips what is available for the social and medical response. The confusion of care, experiment and welfare is also present in the kinds of affect that knot women to the clinic, in the pleasurable rituals of belonging, in the production of experimental sites as clinical space marked by distinctive forms of care. The process of assembling, contouring and maintaining the integrity of the research cohort is accomplished through registered women’s own forms of organization and through the testing practices that mark it out as an exceptional space of care. These observations about women’s *reasons* for agreeing to the terms of regulation and to the work of the experimental regime therefore open up issues about the “psychological impact of institutional settings and the authority of science” (Bolton, 2005, p. 4).

Together in the clinic: Implicating Care

Often while at the Institute of Social Hygiene I would struggle with the idea of *care*. I was conscious that my attachments to certain kinds of care (“warm”, intimate, person to person, non-hierarchical) seemed to be positioning me more thoroughly in the clinic – and distancing me from action – more thoroughly than any other commitment, for example, my feminism. It is clear from my notes that the attention that I paid to care, and my desire for a “more” care, or a different type of care, passed between me and the social workers. In one interview I note that the social worker frequently interrupts herself “reading instinctive shock on my face”, to correct me: “We have to be firm with them; you don’t understand what these women are like”. Two questions occur to me here. The first is to do with my positioning and research practice: what is it about *desiring* – and, implicitly, however unwittingly, arbitrating for – “good” care? Hannah Brown writes on her very similar experiences in a Kenyan clinic, that she came to ask “what can be learnt by thinking about interactions between nurses and patients as relationships of care which can be followed into other domains of social life?” (Brown, 2010, p. 126).

The second question concerns *actually existing* norms and standards of care at the clinic. Despite the occasional “stern” moment, which is often dictated by specific legal requirements that are placed on how the social workers conduct their interaction (for example, dissuading women from registering); the deep mutual respect and care that exists between registered women and the social workers that oversee the clinic is evident. For example, the social workers know the names and ages of the registered women’s children – they enquire about mothers, sisters, brothers, and the registered women refer to them as “my sister”; “my mother”; or “my daughter”, depending on relative ages. Above I examined the micropolitics of regulation and registration and I hope that I was able to give a flavour of the intimate and interpersonal dimension of these interactions and how far these practices sustain the bureaucratic processes and experimental work. I was conscious that observing this “warm” person to person care was very gratifying – I enjoyed the humour and the “role” that the senior social worker played. There was plenty of humour derived from the frequent slipping of the sharp and didactic role into a relaxed and indulgent mode. The head social worker, moreover, had a keen understanding of her own role in the clinic which was strongly inflected by her perceived double role as civil servant and activist. For example, one day

we sat in the office and talked to a friend of hers who had dropped by with a pregnant relative. As they talked about the voice of the people and the thorn in the side of the public administration that they aspired to be, the head social worker invited in a young hawker who was passing through selling cheese. She had seen him outside, she told her friends, and told him to bring his goods inside and sell to the hospital staff and the patients: “He replied no, I can’t, that’s a hospital [*menuma, bii structure la*]; I replied, *just give my name at the entrance* [*yaa jox sama tuur*]. This interaction exemplifies some of the demotic nature of clinic space which the social workers sought to open to all in a rough-and-ready, instinctive version of egalitarian and democratic politics. And this too – in its own way – was *gratifying* to observe.

However, what is important to remember is that there is a *politics to care*. As I explored in the second chapter the “turn towards care” is a sharp critique of how humans and the category of “humanity” is handled in practice. What this critique *never* loses sight of is that “social relations produced through emotion and emotional connection are also understood as *sites of power*” (McEwan & Goodman, 2010 my emphasis). Rather than falling back in the descriptive analysis of *how* the authority of the clinic – and of the regulatory system – inheres in women’s lives on a Weberian tripartite analysis in which charismatic power plays its role and has its own distinct explanatory power; I want to consider the implication of care in the reproduction of power relations across the clinic. Just as at the mobile clinic *knowing* was expressed as a relational achievement based on interpersonal “warmth”, a “something” that seemed to lie outside of what could be captured by speech.

Cared for by the test: pleasure, choice and proximity to the laboratory

I have discussed the banal practices of registration which both begin to produce the women as sex workers, cluing them up as to how they can and should move through the institution, and begin the “un-blackboxing” (Cussins, 1996) of their bodies and care, a process which will continue through the medical research process. I move now to briefly discuss two stories which reveal some of the *pleasures* of membership and clinic attendance.

The giving and testing of blood associated with registration and regulation is done separately from testing associated with the research function of the clinic. If the clinic’s internal blood testing

schedules overlap with the testing associated with the research the clinic staff tend to defer the compulsory blood test until the woman's next appointment. This is a gesture of care and respect for the women (*prélever ici, prélever là, c'est fatigant pour elles!*). The rituals of regular blood testing and the movement of blood sample around the clinic plays a significant part in producing the state clinic as a distinctive space of care and intervention.

The most visible manifestation of the “microspatialities” of disease and care (Hinchliffe, 2001, p. 189) associated with biomedical research and the enhanced laboratory capacity that it has brought is the constant tracking to and fro of technicians carrying cool bags and moving blood samples out of the clinic and into the laboratory. Registered women do not, for the most part, find the idea of giving blood problematic or laborious; they are familiar with the itinerary of blood and swabs and appear to derive feelings of security and pleasure from this circulation. When asked what is special and desirable about the care they receive at the state clinic compared to other forms of care they might opt for, many women respond: “here you give blood” [*fii danga jox dewet*]. Another woman, when I asked why she “chose” registration at the state clinic as she sought out care, replied simply: “here, here is AWA, and close by there is the laboratory” [*fii la Awa nekk, fa am na labo*]. For many of the women at the clinic, membership of AWA and proximity to the laboratory are the two poles of superior care associated with registration. The distribution of registered women’s bodily proxies around the clinic and the laboratory is framed in a “warm” way; it is discussed as a process which secures the high quality of their care. Compliance with testing demonstrates belonging and commitment to the clinic, but there is also pleasure in testing. As Beth Greenhough argues: “[t]he process of bodily commoditization is not just one of alienation .. we might see in the process of becoming technically equivalent an expansion, rather than a reduction, of possibilities, connections and associations” (Greenhough, 2006a, p. 448).

So although the social worker protested to me in the face of my tiresome questions about testing, trialling and the experimental work of the clinic, “everything ‘biological’ is at the hospital laboratory and with the research team”, that is not strictly true. As Jeannette Pols and Ingunn Moser argue, drawing in technologies – often interpreted as the “cold” other to “warm” care – can allow researchers to formulate new questions about “what kind of affective social relations are enabled by medical technologies” (Pols & Moser, 2009, p. 179). Listening in a “realist mode” to

the “events people report on” (Mol, 2002, p. 15) exposes some of the less evident ways in which experiments are lived as social good, and can show up some of the humanist presuppositions which inhere in anthropologists’ readings of technology and biomedicine in the lives of ordinary Africans.

The inside of the outside: making a social [prostitute] body with experiments

The “biopolitics” of the European social policy that was exported to the colonies reproduced the basic *dispositifs* and these *dispositifs* were “always bound to the abstract value measures of labour, even as they were directly mobilised by and for governmental apparatuses such as security and public health” (Staples, 2007 p. 125). I demonstrated these *dispositifs* and their relationships to rational labour value calculations at some length in chapter three when I examined the archive data which was concerned with the long term costs of treating (1) the general population, and (2) the standing “native” army for venereal disease. The colonial medicine that gave way to our current regimes of “global” biomedicine and collaborative research work “operated across a rift of political and economic inequality” and many of these inequalities are sewn into the way that biomedicine is practiced today (Keller, 2006). This is exemplified by findings such as Catherine Waldby and Melinda Cooper’s, that the new market in clinical reproductive labour is “developing in close synergy with pre-existing transnational economies of feminized labour (domestic, sexual and maternal)”, and that women who participate in one economy are likely to participate in another, and by moving between them, make the boundaries extremely fluid (Waldby & Cooper, 2008, p. 64).

Rajan (2005) uses the concept of biovalue to create links between human life and what Spivak has caused the “expanded textuality of value” in late capitalism (Spivak, 1987, pp. 162-163), in other words he coins the term to express how life *generates* value under certain arrangements of regulated labour. He argues that the exploitation of this labour is not, however, a mere extractive “resource-mining exercise” and the reason for that is that biovalue involves *experimental subjects*: “experimentation is a speculative exercise of a very different register, a practice of inquiry that is constantly open-ended” (Rajan, 2005, p. 27).

The question that I posed in the introduction to this chapter remains unanswered: is there a definable *experimental* form which circulates at the Institute of Social Hygiene and which *acts upon the ontological politics at the clinic*? A definitive answer is very difficult to provide, but the complexities that I encountered while struggling with this question in the field might hint at ways forward in addressing this question. There are two different forms of empiricism existing side by side at the clinic (see figure 8 below). Diagnostic medicine is “founded on an evidential paradigm based on individuality and a single event” (Ginzburg, 1986); in this mode bodies are highly differentiated and the experiences of the patient are empirically and ethically prioritized. In the research mode bodies are aggregated into a cohort and made to speak for larger viral and regional differences. The two forms of knowledge are validated through the individual skills of the doctor on the one hand and the formalized production of scientific knowledge and its circulation through peer reviewed journals on the other.

Medicine	Diagnosis & Differentiation	Doctor as a “cultured practitioner of arcane skills” (Lawrence, 1985, p. 505)
Research	Aggregation	Serological archive; publications in journals

Figure 11 Empirical forms used in inquiry at the Institute of Social Hygiene

A first observation, then, might be that the way the experiment knows the body is entirely dependent on the social workers; a clinical “social” or aggregate body could not be composed out of individual physician’s observations without the social worker-bureaucrats who take detailed data from the women and follow them out into the city to ensure they meet their obligations.

Less prosaically, we might consider Deleuze’s observation that “pathological anatomy [subsequently] introduced into the body deep foldings which did not resuscitate the old notion of interiority but constituted *the new inside of this outside*” (Deleuze, 1988 p. 81). Deleuze follows Foucault’s account of the madman in the ship of fools who is imprisoned in the *interior of the exterior* “the fold of the sea”. Deleuze uses this story to argue that there are variety of “modalities of folds”, from material folds such as bodies to foldings of time and memory (Parr, 2005). This

concept is a particularly good one with which to think at the Institute of Social Hygiene as it begins to get us beyond the series of linear transitions embedded in experimentality narratives, moving beyond the static spatialisation of the palimpsest. Moreover in seeing the experiment at the clinic in *opening up a deep folding* which creates new kinds of bodies we can remain sensitive to the work of experimental actors and not assume that the experiment is *doing the thinking*.

I would like to argue that the body produced by experiment/regulation can best be thought of as “intricately coordinated crowds”: “the body multiple” (Mol, 2002). Another way to think the two epistemic worlds of the clinic is to think of the molecular politics of the clinic as “surfacing of a body interior”. For sure, this body interior then brings a whole new range of calculations and valences to the fore, just as the NGO behavioural ethnographies made a range of gestures and embodied differences speak to the difference of the *clandestine*. However, Janelle Taylor delves into some of the subtlety and possibility of this process when she writes that this process is no “slippery slope, no one-way road towards visibility and value. Surfacing remains unstable, its resolution never entirely predictable” (Taylor, 2005 p. 748). Thinking of the women at the clinic as themselves a *public* for molecular knowledge about their bodies – and I develop this in the next chapter when I think about the ethical relationships forced between doctors and patients at the moment of the diagnosis of seropositivity – underlines the complexity of this process. As I examined above, women registered at the clinic took pleasure in testing and seeing their blood circulate knowing that its final destination was the laboratory. Just as the women entangled in the mobile clinic intervention sought knowledge about their bodies and their menstrual cycles, involvement in biomedicine opens up new vistas of knowledge about bodies, knowledges that can be experienced as empowering.

Conclusion: Thinking with experimental politics

Female commercial sex workers, seen as “unsanitary citizens” must “reproduce the official discourse bodily, by adapting hygienic practices and demonstrating subservience to medical authority” (Briggs, 2004, p. 177); a policy with its roots in the colonial era which treated these “public” women as proxies for the Senegalese population has created the ideal conditions for biomedical research. This is a story which exposes the “unseemly affinities between experimental matters of fact, biopolitical modes of rationality, and historically specific forms of governance”

(Powell & Vasudevan, 2007, p. 1791). The women registered at the Institute of Social Hygiene are a population made legible by institutional arrangements that have their roots in colonial sanitary policy, in local scientific recuperations of USAID funded family planning programmes, and in humanitarian intervention, and as such each of these interventions might be seen to be scored with a deep ambivalence. Is this not an example of the practices associated with the disciplining of the body exposing the underlying congruencies between modern ideologies (Agamben, 1998)? Moreover, in the process of making congruent the aims of rationales of regulation and research, have state and non-state actors not further entrenched the variegated citizenship (Ong, 2006) that underpinned colonial sanitary policy? (Agamben, 1998). In this chapter, however, I have attended to the surprising social life of the experiment at the clinic. I argue that there is more to this case than a thickening and multiplying of *historical irony* (Comaroff & Comaroff, 2002); although this is one possible narrative it does not tell the whole story. I have introduced *care* into the equation, a process which involved unpacking and questioning my own assumptions about the nature of “good” care and my desire to intervene to ensure that “best possible care” was the outcome. In this chapter I have argued that the articulation between regulation and research at the state clinic produces highly complex local social and care relations. The evolution of research and regulation at the state clinic is not a single project. In fact, as I explore further in Chapter Seven in my discussion of the contested ground of “ethics” at the Institute of Social Hygiene – the social workers oscillate between acquiescence, enthusiasm, and outright critique of research practices. I do not think, however, that this is evidence of some deep cognitive dissonance on their part. Using care, critique, testing, and the laboratory as devices to gain entry into the mass of ethnographic notes that I took in the clinic, it begins to become clear practice on both “sides” of the clinic are equally implicated in the interweaving of sanitary regulation and experimental relationships.

Tracing the historical affinities and the material transgressions between experiment and governance at a single site offers insights into the multiple actors who have made up these *interventions*. *Building approaches which build on the theoretical backgrounds of both geographies of health and geographies of bioscience* helps to shine a light on the historical and contemporary material transgressions taking place in spaces of health and bioscience (Greenhough, 2010a). These actors have collaboratively created a new kind of regulation which breaks with the practices of sanitary

state policy while still bearing the traces of the state spaces and projects from which this new configuration emerged. Thinking beyond the single world of linear clinical progression – from regulation to experiment – opens up an analysis sensitive to deep foldings of time and the multiplicity and instability of biopolitical processes across molecular and municipal fields.

CHAPTER SEVEN: THE SUBJECT WHO CARES FOR OTHERS: GENEALOGY, SUBJECTIVITY AND THE BIOETHICS OF REGULATION

“Ontology is the territory without morality” (Bauman, 1993, p. 71)

One of the most painful chapters in the history of transnational biomedical research in Africa was the controversy over double blind AZT trials of transmission from mother to child; not least because the affair seemed to expose the limitations of bioethics to debate and define “justice” in experimental work. In 1997 an excoriating article published in the New England Journal of Medicine criticized “unethical” AZT trial-work in Africa for only providing women in the control group with placebos (Lurie & Wolfe, 1997). Assessing the trial, regulators found that it did *not* violate bioethical standards, as the “best available” local form of care was no care, and therefore women in the control group receiving placebos were not receiving worse treatment than they would have done outside of the trial. Adriana Petryna describes this as the watershed moment at which “a cost-effective consolidation of variability in ethical standards overtook efforts to make a universal ethics applicable and enforceable” (Petryna, 2005 p. 187). Adriana Petryna interviews a physician who when recalling that they were instructed to provide the “best local care option”, asks if that was painkillers or vitamin C, as in the hopelessly under resourced clinics in which they were working, these were only medications to which they had any ready access. What is interesting about the particular case of the Institute of Social Hygiene is that the *alternative* to trial work was not “no care”, it was *regulation*. Consistently then the doctors argue that they have *transformed* regulation by “adding” good care, both in the sense of distributing the goods of the laboratory and through the good of exemplary doctoring.

To specialist and non-specialists the debates about perinatal transmission and double blind trials seemed to exemplify the problems with bioethics: highly technocratic, giving too much weight to priorities of scientific innovation over the protection of vulnerable human subjects, and insufficiently responsive to what most people felt *instinctively* was an abhorrent practice: withholding care from women involved in research work. Critiques of bioethics have focused on their “hegemonic” status (Wendland, 2008); the limits of informed consent *in situ* (Tafesse & Murphy, 1998); and their global reproduction of Euro-American and – implicitly – Judeo-

Christian value attachments²⁶. Social scientists and moral philosophers have critiqued bioethics for their “narrow” focus on “procedural questions of informed consent and clinical conduct” (Petryna, 2005 p. 184). The discipline and practice of bioethics appears to be characterized by an “intense formality”²⁷, which drains moral debates of cultural meaning and political vigour. In this chapter I think through the (bio)ethics of *regulation*. I argue that bioethical frameworks have become a way of thinking the good in “mixed” spaces of therapy/experiment/regulation – there is a clear “bioethical creep” in these spaces. However, bioethics as they are understood and practiced in Dakar are not mean, “narrow”, or overly technocratic norms. Rather they express key forms of sociality in contexts of social stress and change and are a means used by professionals to “write” self and other in complex care interventions.

Practicing Ethics

The debate about double blind trials and perinatal transmission exposes some of the ethical problems in transnational or globalized science. If the history of difference in Europe “has been one of the lethal exclusions and fatal disqualifications” (Bradotti, 2003, p. 45), then our own era of scientific *sameness* and bodily commensurability poses its own critical challenges, and critical productions of difference. If bodies located in specific clinical spaces can be used to elicit transferable and travelling knowledge then these questions must be drawn into local constellations of ethical reasoning and complex accommodations must be made juggling scientific urgency, local bureaucratic expediencies, and the shifting policy priorities of “global science”. This “sameness” in the sense of replaceability is always ghosted by difference, a difference always underscored by power relations. On the few occasions when I was able to draw out Mme Faye on the subject of the rights and wrongs of using the clinic as a site of research, she observed that:

“You know, ethics, all that, when it comes to sex workers, it’s really not a problem, they’re the kind of people who... well, what they want is the *carnet*, that’s all they’re interested in.. everything else: forget it.”

²⁶ E.g. Human Embryonic Stem Cell research in India (Bharadwaj & Glasner, 2008)

²⁷ Ellen Rooney cites Frances Ferguson on the “intense formality” of the law on rape in (Spivak, 1993, p. 1)

What Mme Faye is arguing here is that registered women are not (or are not *ideal*) ethical agents because their stake in the research is negligible – as long as they have the documentation that allows them to move relatively freely, to claim some legal rights as they move through the city, then they will be happy. However, she also noted that there are exceptions; there are “intellectuals”:

“There are some who say “No, I’m not interested [in participating in the trial]”, that’s because they are the intellectuals! They don’t want it, they know what research is, why don’t they do it in their own country? They come here and make us [...] and we have to do it!”

There is an important point here in these stories about ethical agency and perspicacity of the few. Mme Faye is pointing out that exercising their right to withhold their contribution to the trial is not produced as a significant ethical choice as women are absorbed in the primary contract at the clinic: the exchange of some autonomy for the right to legally sell sex in the city. However, there are some who can perceive the suspicious inequity at the heart of the research process: why do it *here*; why don’t “they” do it in their own country? It is interesting to note that even here the trial produces difference: a difference between the enquiring “intellectuals”, capable of discerning the power relations that underpin work at the clinic, and the women perceived by Mme Faye as quiescent. These assumptions of an ethical quietude on the part of the women reflects a wider set of cultural stories about the registered women which represent them as being locked into structures of urban male authority – this *despite* the fact that the stories that women tell upon registration bear poignant testimony to the erosion of masculine authority through migration, the contraction of the formal economy, and the economic marginalization of men. When I met with the *medicin chef* of the Institute of Social Hygiene to discuss the “ethical feasibility” of my study he asked what would happen if I spoke to the registered women and then one of the women’s husbands came to him to complain that his wife had been asked questions without his permission. Having at that time already a fairly good understanding of the kinds of women who registered at the clinic and some of the likely circumstances of their lives I was momentarily thrown by this objection.

Paul Farmer has asked, provocatively, if transnational research in the majority world can *ever* be ethical or if ethical relations are a structural impossibility given the power imbalance between

researcher and researched (Farmer, 2002). I do not think that it is helpful to align the Natural History Project with highly exploitative pharmaceutical trials of the kind of Adriana Petryna has studied. Indeed, for me, part of the fascination of the project has been working on a history of a project which went to great lengths to set up collaborative and reciprocally beneficial working relationships and to bring added value to the women who participated in the research. In this chapter I want to continue to walk the difficult path I have traced throughout this thesis in exploring the world of the *regulators*, here I look at their embedded ethical reasoning and consider alternative means of “ethicizing” regulation. The complexity of the relations involved – the “entangled spatialities of connection” that create vulnerabilities (Philo, 2005, p. 450)–however, militates against the research ever being completely benign, and it is the problematisation of these questions and the handling of the “good” of the research regime in practice at the Institute of Social Hygiene that I address this chapter. As I am neither a bioethicist nor a moral philosopher, I do not dwell too closely on normative arguments but pay close attention to bioethics as a means of self-making and world-construction: an increasingly privatized form of moral reason. This chapter is a contribution to the empirical study of “ordinary ethics” (Lambek, 2010), and a particular critique of some of the ways in which bioethics are represented in social science literature: as a fatal congealing or “hardening” of a given community’s moral norms.

In contrast to the two previous chapters this chapter relies slightly less on ethnographic notes and more heavily on interviews with the trial physicians and with staff at Dantec Laboratory, including Professor Souleymane Mboup. As a rough guide I began the analysis for this chapter simply by coding all interview data I categorized as discussion about ethical or moral practice. I then generated a set of meanings and attachments which I discuss in this chapter under the rubrics of global science and bioethics. I continue in this chapter to think with the professional and personal entanglements of the “street level bureaucrats” who must confront and handle different kinds of ethical jeopardy in the course of merely performing the basic functions of their job. To reiterate a point made previously in chapter three, there is little separation or compartmentalization between ‘personal’ and ‘professional’ conduct. The life that these citizen-scientists lead in the public sphere is intimately related to their search for a “good life” (see Collier & Lakoff, 2005); and if I mix up ethics and morals in this chapter it is in a deliberate attempt to disrupt notions of “professional

ethics" and "personal morals".

Anthropological studies of ethics in "ordinary" spaces and practice have focused on the constitution of lay people's moral worlds as they encounter new ethical problems and draw on existing resources to solve them. A study of lay people's discussion of genetic sex selection, for example, identified structuring concepts and metaphors such as "slippery slope" arguments, and the implication of personal experience (Banks, Scully, & Shakespeare, 2006). As Keane argues, part of the "distinctive mandate of anthropology is to encounter people in the midst of things. This mandate suggests one way to think about the ethical as an irreducible components of the politics and pragmatics of everyday life" (Keane, 2010, p. 65). However, my approach to ethics is not entirely phenomenological, that is, I do not think that morality is reducible to experience (although that is how it is sometimes discussed by respondents in this chapter), or that ethical or non-ethical conduct is impossible to critique. I am interested in how the subject becomes a subject who cares for others, and how the conditions under which that subjectivity is formed relate to ethical practice, and to power and care relations at the clinic.

In chapter four I briefly discussed Foucauldian technologies of the self in relation to the mobilisation of affective knowledge by fieldworkers and as a means to think about the professional jeopardies of the research encounter. In this chapter I think about the cultivation of the self through technologies (Foucault, 1994a; Foucault, 1994 [1987] ; Foucault, 1997a) through (1) an examination of the cultivation of physician-researcher selves as ethical knowers – a experiential and embedded discourse cultivated through bioethics; and (2) the experiences and reasoning of the sex workers. I argue with Veena Das that the sex workers' "modes of narration stand out in sharp relief against the kind of questions raised by Foucault on the relation between truth and subjectivity" (Das, 2003, p. 95). Studying "technologies of the self" at the clinic help to expose the conditions under which caring subjects are created and how they understand their work and their modes of relating to others in a complex moral space. Data elicited in the context of conversations and interviews can begin to expose the profound ethical questions articulated by Vikki Bell:

"How have I been produced as a subject who cares for others? What are the conditions and the limits of my care for others? How has the moment in which I become ashamed of my

freedom and am prompted to think and feel differently been constituted for me? How have the moments in which I do not?" (Bell, 2001, p. 168)".

Out of what material resources and personal experiences do we individually and collectively make and contest ethical regimes and make ethical decisions weighing the "good" of our work? Foucault's idea of "moral subjectivication" involves an analysis of the *local resources* available for "setting up and developing relationships with the self, for self-reflection, self-knowledge, self-examination, for the decipherment of the self by oneself, for the *transformations that one seeks to accomplish with oneself as object*" (Foucault, 1990 p. 29, cited in Mahmood, 2005 p. 28). These materials and these subjective transformations are undertaken with the local resources of the clinic, between doctors and patients, but also through a series of spatial and temporal displacements which locate scientific research within larger frames of understanding the "good" and the "right", and it is to the constitution of these larger frames that I now turn.

Moral geographies: "local" moralities and "global" science

Intersections of geography and morality suggest that "issues of space, place, environment, landscape and so on are often built into the very heart of moral arguments and assumptions" (Cloke, 2002, p. 589). Moral questions become both more tangible and more complex when they are embedded in particular time-spaces. As Hacking argues, "the genealogy to be unraveled is how we, as peoples in civilizations with histories, have become moral agents, through constituting ourselves as moral agents in quite specific, local, historical ways" (Hacking, 2002, p. 3). So far in this thesis I have thought about the clinic as a space where different kinds of license (to transact with a state-defined population), and restrictions (upon one's individual behaviour, against the violation of medical secrecy) play out against one another. Working out how ethics are interpreted and practiced at the Institute of Social Hygiene entails the "disrupting [of] entrenched cartographies" (Whatmore, 1997, p. 37) to trace the relationships that run through the clinic, linking up this locale to a range of other sites.

In the large assemblage of actors who are using data from the clinic, collaborating with the teams, and driving the project of creating a research site forward local physician-researchers sometimes

have relatively little influence over the definition of the goals. Souleymane Mboup, for example, told me of times when he had been simply “told” by European scientists to draw blood from the women registered at the clinic and send it to their laboratories, it was understood that non-cooperation was not expected from a “local” scientist seemingly located at the bottom of a very long chain of command. His solution to their peremptory and insulting communication was characteristically politic: he sent samples but made sure that they were spoiled, so that the foreign laboratory could not use them. Steering the Natural History project through to its conclusion and maintaining a degree of local ownership involved hundreds of similar “tactics”. The physicians at the Institute of Social Hygiene also told stories about how external researchers had requested photographs and personal data from the women enrolled in the trial, failing to understand the special nature of the clinic, the priorities of the women who were registered there, and the extent to which research participant retention relied on maintaining trusting relationships. These requests placed the Senegalese researchers in a highly awkward position. Despite their desire to maintain cordial relationships and their natural courtesy they had to insist that the women’s anonymity be respected and that the idea of being photographed would be frightening and invasive for women at the clinic.²⁸

What interests me, however, is this construction and defence of the “local” space of the clinic. I am interested in this chapter in thinking about the “morality of scale” (Whitehead, 2003), as it is interpreted at the clinic, the local scalar imaginaries through which the staff and the sex workers construct ideas about their relations with other actors in the chain of research.

Locating the laboratory: morality, autonomy and the re-territorialisation of research

Souleymane Mboup tells the story of the initial discussion at Harvard when he was asked what he would like as a reward for having brought the extraordinary “gift” of the molecularly peculiar virus. “I answered, I want a laboratory”, he told me. At the Institute of Social Hygiene the doctors constantly stress the material benefits that the trial has brought, “everything you see here, the trial

²⁸ Enda santé also suffered from this problem. In their case, however, the problem was more acute as mobile clinic donors had a pronounced and prurient interest in seeing the faces and hearing the stories of the women whose care they were funding. In one horrible incident photographs taken of Enda’s clients at a focus group were leaked to a Senegalese newspaper and one of the fieldworkers received death threats from the outraged families of the women portrayed.

built it", as one doctor said to me. In evoking the changing face of the laboratory they are evoking something quite precise: the arrival of the laboratories which permitted them to do microbiological work in Senegal. Here one of the doctors discusses changes in the "infrastructure" of the clinic brought about by the arrival of the trial and its bilateral funding:

"Infrastructure, yes, there were both changes in the infrastructure and in the ways in which we treated the sex workers. Before they just arrive and then, well, we treated them in a couple of minutes; just a very brief consultation then we signed the carnet and they left. But then there came a time around 1986, 1987 - we signed an agreement between the University of Dakar, the University of Limoge and the University of Boston - Harvard. We called it "the interuniversity agreement on research into the virus", and in Senegal we would focus particularly on sex workers. Suddenly there was a whole team: pharmacists, doctors, nurses, social workers; and we started to set up, little by little, more scientific teams so that we could do things much more by the book - I mean so that we could have a laboratory that worked, which was capable of diagnosing STIs, and so that the doctors could treat STIs if one were diagnosed: gonorrhoea for instance, those diseases which we practically don't see anymore; and it would also allow us to offer the HIV test and to follow those who were infected and those who would become infected."

This is a story not only about improved care for the women, but also implicitly about unlocking local laboratory space, making it accessible for students, scientists and clinicians. Before the Natural History project was launched, Souleymane Mboup worked at the university, the institution which controlled all scientific training and activity. Now the laboratories that the trial work has brought are embedded in two public structures: the IHS and Dantec Hospital, providing lab-work indiscriminately for patients. On this level the research project is an extremely positive story about postcolonial science.

At the Institute of Social Hygiene Dr Sy told me another story, this one is a version of the Mboup's canonical "discovery" narrative.

"Actually it was Professor Mboup, when AIDS started, I don't know why but he had drawn blood samples, and when he sent the samples to France he put the letter "S" on them, an "S" to show that they had come from Senegal; but in France they thought that S meant that the samples were taken from monkeys [singes], so people didn't look. Before, we couldn't do the test here, the biological test, so when people assumed that it was a monkey sample, [Mboup] waited and waited and he didn't receive any results. He asked them,

“where are my results?”, and they said they were not going to do the analysis as it was a sample drawn from monkeys. He said “no, it’s not a sample taken from a monkey it’s taken from a patient!” When they did the test they realised that while there was a resemblance [to HIV-1] that it was not... that it was *different* to HIV-.. that was how the virus was discovered, and it was after that that we started to do tests here, before, every time that we drew a blood sample we sent it to France”.

The doctor was visibly angry when he told me this story and he told it in response to what he thought were my increasingly obtuse questions about the cultural and viral specificity of the Dakar clinic – that is, I was following my interest in the confluence of factors that had made the clinic a space that could sustain cohort studies and produce powerful scientific knowledge about HIV. He told me this story to illustrate the *obscene error* that had taken place in the laboratory. The purpose of the story in context was to illustrate the ethical urgency of African scientists taking charge of the research project.

Nikolas Rose writes that molecularisation strips “molecules of their specific affinities ... to an individual, to a species..” (Rose, 2008). It seems to me that this anecdote, although it slightly garbles the “real” story, makes an important kind of sense about an *ethical problem of affinity*: in particular it is very powerfully about the affinities between species that was patched-together through the administrative error in a French laboratory. Recalling as it does key tropes of scientific racism, this is a story that brings to mind Luise White’s vampire rumours, the rumours which evoked power to “cross boundaries, violate space, capture vulnerable men and women” (White, 2000, p. 9). As Wolfe (2003) argues, the “discourse of animality has historically served as a crucial strategy in the oppression of *humans* by other humans - a strategy whose legitimacy and force depend, however, upon the prior taking for granted of the traditional ontological distinction, and consequent ethical divide between human and non-human animals’ (Wolfe, 2003, p. xx). Achille Mbembe writes on the continuing salience of colonial scientific racism to African identity arguing that the “apologetic density of the assertion ‘we are human beings like any others’ can be gauged only with respect to the violence of the denial that precedes it and makes it not only possible but necessary” (Mbembe, 2002, p. 254). For African scientists the violent denial of African personhood and the accidental (but suspicious) transgression of primate-human boundaries

through a laboratory error highlighted the vital *ethical* importance of working as independently as possible.

If it was considered ethically appropriate for the scientists to establish a paternalistic relationship of control and protection over “their” women in order to avoid both *error* and *exploitation*, there was also a commitment to ‘work’ the cohort data in the service of pan-African science. In the 1990s the significance of the HIV-2 infected cohort on a “global” scale was thought to reside in the potential to unlock the mechanisms of infectivity and therefore to find a viable vaccine against HIV-1. The team pursued this goal enthusiastically despite a rather lukewarm international reception to this strand of their work. When I asked the research physician at the IHS about the vaccine they replied guardedly but humorously that the vaccine was a very difficult question. At le Dantec, however, Mboup and his team have a different recollection of that time, as one man told me there:

“We realized very early on what we as a team here were interested in. Because this type of virus had been discovered in *Africa* it was of great importance that African scientists played a big role, because the results – and the vaccine – had to be applied in Africa”.

Many of the decisions which locked the experimental work into the path down which it subsequently developed – including some high profile publications which rather damaged the credibility of the team who were subsequently thought to be leaning rather heavily on data drawn from a small cohort – were driven through by Dakar’s citizen scientists who were preoccupied with questions that were formulated in a decade marked by scientific activism in favour of the distribution of anti-retroviral drugs beyond the minority world. The future as a “conceptual possibility” (Adams, Murphy, & Clark, 2009, p. 247) therefore played a central role in the development of the research regime, and the imagining of these futures was a “passage through affect” (*ibid*) forcing the scientists into an engaged analysis of the lack of resources in West Africa.

Being affected: laughing and crying

In the context they were working in it is perhaps not surprising that the Senegalese scientists and doctors were so united and focused on this imagined outcome of stamping African scientific sovereignty over the potential “miracle” vaccine. Talking to the doctors at the clinic it is clear that the primary and motivating ethical experience they had there was breaking the news to the women they had grown to know and to care for that they were infected with HIV. Before 2004 antiretroviral drugs were unavailable in Senegal. This “natural” fact was, of course, what enabled the Natural History project – as it created local conditions under which it was ethically feasible to study the progress of the virus through individual bodies ‘unimpeded’ by drug interventions. The Senegalese state has a policy of continuing to monitor HIV positive prostitutes and compels them to continue visit the clinic at regular intervals – if they do not they will be breaking the law. The staff at the clinic, therefore, continued to see the women and the physicians travelled to their homes when they were too ill to attend the clinic and monitored their viral loads until they died. These encounters, it seems to me, were corporeal engagements that – as Nigel Thrift puts it – “amplified responsiveness”, and enhanced the “affective capacity” of the scientists (Thrift, 2004). Initially I was concerned in my research only with juggling the political-economic agency of women in the city and the material-semiotic agency of their bodies enrolled as ‘data’. “Adding” the capacity to affect and be affected to clinical encounters exposes more of the history of the experiment.

Another scientist that I met in Dakar, however, had a different story to tell about affect in experimental life. He queried my approach and suggested that I was “too close” to the scientists to see the “real story”. “They laughed”, he said bitterly, “when they heard that another woman was infected with HIV they celebrated, because their cohort study needed enough women to be infected with HIV-1 and HIV-2 in order to produce viable comparative data”. The irruption of this laughter, this obscene affect, occurred for this observer at a thoroughly inappropriate intersection of instrumentalised bodies. How could the men who provided these women’s care move from celebratory mode at the laboratory into caring mode in the clinic? For him, it was simply an impossibility. Worried that I could not look into the scientists souls and discern the ‘real’ affect; I turned further away from emotions at the clinic: better to talk about practices and poverty than to risk discussing fraudulent affects. In working through the data, however, I have reconnected with some of the ethical difficulty and moved towards an analysis more susceptible to discontinuity,

risk, and approaches to the formation of experimental subjectivity that can conceive of both laughter and tears as affective responses that shaped the shared experimental life of the scientists and the subjects of regulation/experimentation – the cohort of prostitutes registered at the clinic.

Laboratories, moral landscapes, and ethical expertise

It is clear from the scattered stories retold above about producing science on the “epistemic periphery” (S.M.Reid Henry, 2010, p. 162) that the spatialisation of research is highly important in the figuring of morally appropriate care relations. Transnational biomedical research is a form of technoscientific practice that “coproduces new form of worldwide relationality and living (im)possibilities” (Vora, 2009). Catherine Waldby suggested “biovalue” as a means of capturing the relationships between the living and the dead as tissue donors and recipients (cited in Rose, 2008: 42). In this case, however, the relationships that create ethicity and non-ethicity are relationships that cut through temporal and spatial fixes. The forms of power-saturated relationality that underlie the research intervention at the Institute of Social Hygiene are multiple. Professor Mboup orientates in his discourse towards an ethical relationship with other African scientists, who might in the future benefit from the “African” stake in the HIV vaccine project which his team tried to establish.

The stories above help to illuminate some of the spatial and temporal complexities of establishing and defining ethical conduct at the Institute of Social Hygiene. I now move on to a far more intimate investigation of site and place, focusing on the clinic itself and the physician scientists who work there. Observing in practice some of the tensions between ideal ethical relations and “things as they are” at the clinic, and feeling that some of the compromises between the bureaucracy of regulation and the emancipatory global science project were a little clumsy, I asked myself questions about the overlapping local moral cultures at the clinic. Is there a single distinctively *local* moral culture, a culture which might be woven through norms of technoscientific practice in order to ‘ethicise’ practice, ground it more firmly in the moral worlds of the differently located participants?

This “bedding down” is a familiar spatial trope in the sociological study of bioethics. Researchers

studying the circulation of the biosciences in Africa have focused on how research ethics can be “embedded” in the kinds of moral considerations and contestations that are “local” to the research site (see, for example Kelly, Ameh, Majambere, Lindsay, & Pinder, 2010). This implies that bioethical discourses and practices and modes of understanding are fundamentally extraneous to the local, and that careful accommodations need to be made to align the bioethical with the moral universe of research participants (Kleinman, 1999). Petryna (2005) argues that the focus on bioethics has “an abstract philosophical discourse grounding a set of codified norms for medical practice in research”, has led to a “profound disconnect” between bioethics and local moral worlds. Judith Butler cites Adorno on the “problem of morality”, which arises when the claims of “universality” cannot accommodate the “rights” of the individual. In this case, “the universal appears as something violent and extraneous and has no substantial reality for human beings” (Adorno, cited in Butler, 2005, p. 5). The intellectual pedigree and the intuitive sense of this idea are both impeccable. These ideas look back to Kant who argued that only freely chosen acts of a rational agent could be moral, and that any attempts to curb the freedom of action of this agent would lead to tyranny and to immorality (Kant, 1996 [1793]).

As Vikki Bell argues, “[t]he ethical relation .. is the asymmetrical moment before the banality of customs and the impersonal symmetrical form of laws” (Bell, 2001, p. 162), between experiential knowledge and the imposition of an injunction to act in a certain way. However, the precise contours of this “ethical moment” are possibly more complex at the clinic than they may first appear. Take the following exchange from an interview Dr Diouf at the Institute of Social Hygiene:

“What do you think the difference is between ethics and morals?”

“Maybe morality is more individual – it’s about your upbringing, your morality, your probity, and that prevents you from doing certain things. But I think that ethics is based on something quite scientific, something quite objective, which tells you – you can do that, you can’t do that, you can do that, you can’t do that, because – in the past – we did that, and we realized that it wasn’t good at all, it wasn’t the sort of thing that we should be doing.”

It appears to me that Senegalese scientists are consciously building ethical identities through

bioethics – an ethical identity which is based, perversely perhaps, on the *doing of harm*. People who in the past have had direct experience of experimental science which – perhaps – violated the ethical norms that are accepted in the present, these are the people who are empowered to speak. Their knowledge of bioethics is personal, biographical, embodied. There is of course a very profound set of power differentials which feed into and which are exacerbated by this interpretation of bioethics. If bioethics are practical, experiential knowledge, they are controlled by those who have access to a laboratory and unavailable to those who do not. Proximity to the “centres of calculation” (Latour, 1987: 215), then, not only guarantees the “power to reason” (Hillier & Penn, 1991), they also grant people the power to make ethical calculations, to mobilize ethical knowledge and to practice ethics “correctly”.

My argument here is that bioethics is not *in practice* the ‘narrow’, ‘rigid’ framework – a ‘petrified’ morality. I have considered bioethics in Dakar as *local, embedded, experiential knowledge* – it emerges from the practice, reasoning and accounting of Senegalese research scientists. This local mobilisation of a “global” discourse has served to entrench and shore up consent for scientific practices. It has also made virologists the people most empowered to speak to ethical and appropriate behaviour in a broad range of biomedical environments. This might be taken to show the process that Foucault calls the “constant interaction” between the four major “technologies” that shape behaviour and action: technologies of production; technologies of sign systems; technologies of power, and technologies of the self (Foucault, 1994b). Following Foucault, ethics includes our responses towards invitations to self-fashioning, and that these means of crafting selves is a practice and an ethic of freedom (Foucault, 1988).

Seeing the laboratory as a site for the construction of a moral self shows how – for better or worse – we construct identities and relationships in relation to and through technologies. Two points flow from this vignette and from this observation. The first is a reiteration of the point that I have already made in Chapter Five about not just *including* but *implicating* the politics of care. If emotional relationships, warm memories, a sense of self, are implicated in a sense of ethical behaviour which might generate violent exclusions – then those affects must be identified as politically salient. Second, this analysis is in direct opposition to Heideggerian ideas of technology

that urge that in order to “become moral and human once again, it seems we must always tear ourselves away from instrumentality, reaffirm the sovereign of ends, rediscover Being; in short, we must bind the hound of technology to its cage.” (Latour, 2002).

To try to get some purchase on these ideas I return to Butler and her analysis of Adorno’s ethics that must be appropriated in a “living way”. Butler argues that in the analysis I have argued is implicit in sociological writing on bioethics, ethical norms exist “at an exterior distance” from the subject who must assume those norms and establish a “living relation”. Butler then goes on to ask if Adorno considered that “norms also decide in advance who will and will not become a subject. Did he consider the operation of norms in the very constitution of the subject, in the stylization of its ontology and in *the establishing of a legitimate site within the realm of social ontology?*” (Butler, 2005). So far I have deconstructed the discourses and practices of ethical reason at the Institute of Social Hygiene. This form of reason, I will now argue, can be contrasted with the moral reasoning of the women registered at the clinic, and that moral reasoning is intimately linked to the framing of the subject within the realm of social ontology given at the *clinic*.

Registered women’s guerrilla critique : *souci de soi* and auto-bio-politics

As I explored in the previous chapter which looked at care and experiences in the “hinterland” of biomedical research, the clinic is a social space, a space for sharing experiences. In fact, when women are registered they are explicitly instructed to share their problems with their peers and that this will help them to solve those problems [*faj sa bopp*]. It is true that the peer educators work hard to make the clinic a welcoming space and that women visiting for the first time often break down with the relief that comes from being able finally to share their stories and their worries with women who are in the same situation. However, it is noticeable that although women talk constantly about money they are very guarded about discussing their own financial situation, their small money generating *projets* and their income from prostitution. The conversations that I observed women having at the clinic and in which I participated are characterised by a series of moral interrogations about how a good and “correct” life can be practiced in the environment these women work and live in, an environment in which their opportunities to live “proper” lives,

as women, wives, mothers and Muslims, are radically constrained by their social and economic circumstances. These conversations are shot through with differentiation, generational hierarchies, and particularly dense and difficult moral reasoning around money and wealth. During one animated conversation about the morality of *genn* (going out, soliciting), one woman drew me into a conversation: “If you have a fridge, if you have some possessions, don’t go out!” [*soo amee frigo, soo amee tutti biens, du genn!*]. These conversations about being “good”, when meeting the moral standards expected of women in Senegalese society is something definitively beyond the reach of these women, turn on the difficult of defining the threshold of wealth, the point at which a woman is comfortable enough that she should not be reliant on income from prostitution. The calibration of this threshold is an essential part of self-presentation and peer discussion at the clinic, and a different thread of the discourse of ethics that happens at the Institute of Social Hygiene.

However, this talk of doing and being “good” is a “guerrilla” or tangential critique. It is not aimed at the regulatory or experimental regime. It is a frame of reasoning derived from the life worlds of the women who are registered at the clinic. It corresponds closely to the moral worlds I discussed at length in Chapter Four. “Reconciling” these narratives of “good” modes of conduct with the world of bioethics would not be a straightforward “ethicizing” project.

Further, the women who are members of AWA often draw attention to the good work done by AWA in preventing HIV from reaching the “general population”:

“AWA ligeey bu mag moo def ... dangay ko wara doole, ndaxte nun, devant sidaa bi, menunu *rester bras croisées* te gis maladie bi joxee ci *population générale*”²⁹

This is a statement of auto-bio-politics, this statement slides along the scale from individuals to collectivities and urges support for AWA on the basis that they are encouraging women to take an appropriate amount of individual and collective responsibility for protecting the “general population” from the threat of a generalised AIDS epidemic in Senegal. In Chapter Three I

²⁹ “Awa do a great job and you should support them, because us sex workers, we cannot *remain with our arms folded* faced with AIDS and let the illness spread into the *general population*.”

addressed some of the anxiety about “prostitutes” in Senegal’s singular epidemic in a chaotic city which provides the matrix for intervention, linking otherwise unrelated bodies (Grosz, 1992, p. 243). Here I turn to some of the social and psychological effects of these stigmatising discourses. For the women who are registered at the clinic and who participate “successfully” in its rituals – successful in the sense that they succeed as defining themselves as *animatrices* and thus win the moral support of the clinic staff and the material patronage of AWA – ‘writing’ themselves as “responsible” citizens who will not allow the diseases which disproportionately affect them and their friends to be transmitted “*into the general population*” is affective labour which is constantly required of the registered women.

Foucault writes that the Beveridge plan of 1942 was a turning point in biopolitical reason: rather than treating a healthy population as a resource for the state, states are considered to exist to benefit the health of individuals (Greco, 2004). At this time, health illness and the body “began to have their social locations and, at the same time, were converted into a means of individual socialisation” (Foucault, 2004, p. 7). The technologies of self mobilised by the registered sex workers are intrinsically interesting, but they are also providing a fascinating counterpoint to the ethical self-crafting *with and through* bioethics which I have argued is undertaken by health professionals. Veena Das in her own provocative reading of “self-writing” in the context of poor Indian’s treatment seeking itineraries, notes that the people she speaks to are crafting selves in ethical relationships to others, but that: “the gaze of the other is inverted *or punitive* – surveying you but always failing to acknowledge you” (Das, 2003, p. 101). Defending one’s self against stigmatizing identifications, preserving a sense of self in the face of stress and difficulty, these are the self-making activities in which the women engage. Can this work be taken and transformed into critique? I do not want to suggest, as Mme Faye did that (almost) all of the registered women are deficient or inadequate moral agents, fundamentally uninterested in their place in the chains of ethical relationships that uncoil from the clinic. However, an ethical politics which sought to “bed down” trial-work in the moral worlds of registered women would have to be cognizant of the local realms of social ontology in which these women gain local clinical identities as patients, *anciennes* or registered “prostitutes”.

The biopolitics of regulation: setting limits, writing futures and making-up bodies

The concern with the capacity of technology and technoscience to alienate individuals from their fundamental moral commitments is a constant preoccupation in modernity. Edmund Husserl argued that the “exclusiveness with which the total world view of modern man, in the second half of the nineteenth century, let itself be determined by the positive sciences and be blinded by the “prosperity” they produced, meant an indifferent turning away from the questions which are decisive for genuine humanity” (Husserl, [1954] 1970: 6). Adorno and Heidegger wrote of the intellectual history of the concern with the finding and placing “limits” on technoscience and technoscientific development (see also, Winner, 1986).

Some have argued that the “ethicisation of the political signifies its dilution in the private domain, in personal everydayness, the desertion of political collective transformation” (Puig de la Bellacasa, 2010). In this chapter however I have looked at the practice of ethics and power, arguing that the frameworks which are erected to define ideal relations in technoscience in fact contribute to the shoring up of the power of scientists, when scientists are judged to have acquired enough experiential knowledge of “doing good” though being in close proximity to the laboratory. This chapter has exposed some of the close links between biology and biography, not only in order to demonstrate the cultural embeddedness of science, its location in a set of situated knowledges, but also to show the links between scientific experience and *subjectivity*: “a socially mediated process of entitlements to and negotiations with power relations” (Braidotti, 2011, p. 18).

Foucault wrote that he had attempted “a history of the organization of knowledge with respect to both domination and the self” (Foucault, 1994b, p. 225), I have argued in this thesis that the crafting of selves that can exercise forms of specifically and strategically attenuated forms of power is central to bioethical practice in Dakar’s clinics. This chapter has focused on a series of interrogations and partial, local answers to the problem of *how to define good conduct in technoscience* (Keulartz, 2004; Latour, 2002; Winner, 1987). The question of ethical or morally appropriate conduct is intrinsically related to freedom and the distribution of freedom as the means of controlling outcomes in a given sphere, it is also, I argue, related to *difference*.

It has been my argument in this chapter that bioethical practice in Dakar is an attempt to accommodate difference. For example, the research scientists mobilize local bioethical prerogatives when they assert the cultural specificity of “their” women and “protect” them from the perceived predations of global science. Research physicians, social workers, and registered women are concerned with teasing out and handling in practice the difficulties of integrating a research project into the highly specific clinical environment created by state sanitary regulation. However, the effects of these attempts are highly ambivalent. Bioethical discourses in practice strongly spatialize the knowing and feeling spaces of intervention, rewriting bioethics as expertise and circumscribing the kinds of subjects who can make claims upon them. A practice whose stated aim is to make room for differences of gender, race, class, and location in the accounting of the project, in fact creates complex new forms of differentiation: between “intellectuals” with highly developed moral selves and women who are uninterested in the experimental project, and between scientists who have acquired ethical knowledge and lay people who have not.

In this way, the practice of bioethics is implicated in the production and reproduction of subjectivities; and therefore in the *ontopolitics* of the clinic. Perhaps it is not surprising that bioethics is closely linked into bio-onto-politics. After all, bioethics might be identified as part of a longstanding project to integrate different “others” into the Enlightenment project by guaranteeing protection from certain harms. Rather than being inimical to or opposed to it, bioethics are constituted on the “common discursive terrain”³⁰ as the “biopolitical paradigm” (Epstein, 2009) which governs sanitary regulation.

My argument here is that in seeking to write the genealogies of modern bodies and attempts to regulate them, we must pay as much attention to the processes and instruments that attempt to recuperate what is *distinctively human* and protect it from instrumentalisation, as we do to the similarities and congruencies of attempts to control and exploit bodies across different times and spaces. I am moving now towards making more explicit in this final chapter the relationship

³⁰ Achille Mbembe writes that Enlightenment discourse about “race” functioned on this single terrain: “As Paul Gilroy shows, the extensive debate as to whether “Negroes” should be accorded membership of the human family was central to the formation of the modern episteme” (Mbembe, 2002, p. 245).

between the ethos of the gendered human body and the technologies which are used to understand, regulate and intervene upon that body. In order to answer these questions it is necessary first to ask what kinds of ethical jeopardy are engaged and planned for; and second, what apparatuses are developed to manage and mitigate potential ethical harm.

Conclusion

Bioethics, with its rhetorical and pragmatic interest in horizons of control and technical regulation is clearly an ethical system in the sense that it is composed of “self-denying values which inform law-like obligations” (Laidlaw, 2002, p. 317). However, the role that bioethics plays in the clinic goes beyond the handling of abstract ‘laws’ and their application to encompass the definition of moral spaces, appropriate relations, and ideas of sexual and geographical difference. “Expert” discourses of bioethics have the effect of writing subjectivities which create spaces of moral experiment, and determining access to these spaces limits the distribution of capacities to feel and to reason ethically.

I began this chapter with the moral geographies of the clinic and the stories that researchers and scientists told about “national” and “local” science and the proximity of researchers to “their” subjects. There is a particular “conceptual topography” (Driver, 1988) of ethical discourses of the good and the right in experimental work. “Local” sciences in non-Western settings represent “points of intersection between the globalization of a Western scientific rationality, on the one hand, and a distinctively local ‘experimental’ milieu on the other” (Reid-Henry, 2010, p. 2). Research scientists in Senegal struggle to ensure that the benefits of research funding are disbursed between the research participants in a meaningful way while at the same time building a sustainable local culture of science outside of the colonial networks centered on the *Institut Pasteur*.

Second, I thought about how the frameworks which are erected to define ideal relations in technoscience in fact contribute to the shoring up of the power of scientists, when scientists are judged to have acquired enough experiential knowledge of “doing good” though being in close proximity to the laboratory. Finally I considered the alternative ethical viewpoints, the moral

reasoning in which a socially situated ethic could potentially “bed down”. It seems to me that the dominant local forms of moral reasoning are not amenable to being brought into dialogue with bioethical norms. They are a tangential, a guerrilla form of reasoning. In this respect I part ways with Alison Jaggar who claims that classical discourse ethics can inform feminist grassroots action (Jaggar, 1998). I used a discussion of “auto-bio-politics” at the clinic to think about the ethical implications of *souci de soi*, and the work that women are required to do upon their selves as they enter the space. While I am skeptical about the potential of the pat conclusion that “extraneous” bioethics should be “bedded down” into a community’s indigenous forms of moral reasoning, as I think that overlooks the a priori embeddedness of bioethical reasoning; it is clear that mapping local stories about what is “right” when it comes to research can generate a “more thoughtful search for solutions to problems of equity” (Wendland, 2008, p. 2) and it is this line of inquiry that I have pursued in this chapter through an interrogation of research scientists own ethical methodologies.

The differences and inequalities inherent in the practice of ‘global science’ force doctors into relationships with women registered at the clinic which are framed in paternalistic terms of ‘protection’, a custodial relationship that also safeguards the practice of ‘good’ science (avoiding error and exploitation). However, the work that the doctors have done and continue to do at the site clearly “enhance [their] affective capacities and engender new forms of engagement and responsibility” (Popke, 2009, p. 92). The forces internal to the experiment shape caring subjectivities that contribute to the conceptualisation and practice of ethics which result “never fully resolvable quandaries, emotional risks, and ‘permanent complexity’ – coupled with unswerving reflexivity and compassion in the midst of it all” (Haraway, 2008, p. 643). In this chapter I took the contradictory accounts of affect at the clinic and thought about how both laughing and crying are affective and ethical responses that force an examination of this complexity and the profoundly difficult ways it is personally experienced and woven into scientists’ sense of self. In the striated space of the clinic registered women’s self-writing is implicated in the reproduction of a self which is saturated with a different and particular kind of affect – women struggling to posit themselves as responsible citizens who will not pass on the virus to the “general population”.

In this chapter I have been working with Veena Das's thought provoking work which takes late Foucauldian ethics of the self into postcolonial clinical spaces where ethics of bodies and selves are being constantly practiced and remade. Rosalyn Diprose has critiqued Foucault's analysis of the classical aesthetics of the self on the grounds that Greek self-writing disqualified women on two counts. First, women's use of pleasure was derived from their *given social roles* as wives and mothers; and second self-mastery was tied to an "essential masculine structure of active virility" (Diprose, 1994, p. 30). Within the space of the clinic registered women's ethics are tied to the role that the clinic assigns to them: the control of their problematic bodies in the pursuit of the biopolitical goal of safeguarding the health of a *national* population. This suggests that looking to the processes through which selves are constructed can expose not only creativity and pleasure but also coercion, unpleasure, bad affect, and the struggle to live with a 'spoiled identity' (Goffman, 1968).

CHAPTER EIGHT: EXPERIMENTAL FUTURES

Article 2 of the *Loi du 24 Avril 1946*, otherwise known as the *Loi Marthe Richard*, promulgated in *l'Afrique Occidentale Française* in December of the same year, laid out the four aims of the new framework for sanitary regulation:

- A/ *De dépister les prostituées vénériennes voulant se dérober au traitement de leur maladie*
- B/ *De permettre la régularité et l'achèvement des traitements prescrits par les médecins chargés du contrôle sanitaire de la prostitution*
- C/ *De faciliter la reconstitution rapide du carnet sanitaire d'une prostituée ayant égaré celui qu'elle possédait*
- D/ *De rassembler des informations complètes et précises présentant un intérêt statistique épidémiologique et sociologique indiscutable*³¹

Diagnosis, treatment, bureaucratic support, and research: these four aspects of “regulation” have remained consistently at the heart of the new interventions carried out since the early 1980s. In this thesis I have argued that the striking colonial and postcolonial continuities in the legal regulation of commercial sexuality in Dakar can be explained by the fundamental changes that have taken place in the spatial organization of that regulation and the new regimes of expertise which have been integrated into its practice.

Throughout this thesis I have made bold claims for the two quirky clinical histories I have studied. I have argued that the story of sanitary regulation in Dakar exposes some of the most fundamental changes that have taken place in Dakar over the twentieth century, shedding light on the “capturing” of late colonial and early post-colonial modernization programmes by new actors from NGO-led social development and “global” technoscience. These recuperations have resulted in a set of interlinked changes on different scales on the onto-bio-political constitution of the

³¹ To diagnose “venereal” prostitutes who wished to seek treatment for their infection; to permit the correct administration and the completion of the course of medication prescribed by the doctor empowered to do so under the sanitary control of prostitution; to supply a new sanitary card as quickly as possible to a woman who has lost hers; to collect the most complete and precise information possible that has a clear epidemiological and sociological interest.

“prostitute” body along lines of difference which have radically changed the ethics and practice of regulation.

In search of spaces where regulation has been materialized, contested, and experienced, I focused on two clinics. I traced the processes through which Enda skillfully inserted the mobile clinic programme into the existing repertoire of services in women’s health in the city. I take the Enda mobile clinic programme to be exemplary of “transnational NGOs dedicated to researching and managing other cultures in ways which replace colonial forms of governmentality with neocolonial forms of flexible governmentality” (Castañeda, 2006, p. 136). The neoliberal austerity measures which roll back the state’s presence in the everyday lives of its citizens also creates new spaces for new knowledge projects which respond to and categorize new kinds of body-city relationships.

Enda created the mobile clinic as a space marked as alternate and apart where women could get the health care they needed, and established a set of relationships that crossed class and neighbourhood lines – networking women to people who had the necessary kinds of capital to help them out in difficult situations. The forms of triage practiced at the mobile clinic were elastic and often improvised – ways of knowing *clandestines* that grew up with and around ethnographic and clinical practice in highly innovative ways. In the second half of chapter five I discussed the application of these practices through a close reading of micro-interactions of a new group of women, coalescing under Mamadou’s tutelage. Building on the analysis in chapter four of *mbaraan* and contemporary urban sexuality, I argued that the “prostitute” subject is enacted by Enda in the space where that flexible identity overlaps with certain key expressions of working class femininity. Thus, women’s desire to be recognized as particular kinds of urban subjects meshes with the triage procedures of the mobile clinic programme. The ethnographically informed knowledge project at the clinic, therefore, has had the effect of condensing the meaning of *clandestine* into a particular and *ferociously embodied* identity. In constituting the always unstable body of the “clandestine prostitute”; the “mythic, textual, technical, political, organic, and economic dimensions implode. That is, they collapse into each other in a knot of extraordinary density that constitutes the objects themselves” (Haraway, 1994, p. 68).

This “object” is a new bureaucratic identity, the “clandestine”, which can be resisted or taken up in a partial and provisional way by women using the mobile clinic. Enda’s *Cartographie* – the document that seeks to represent the spatialization and practice of clandestine commercial sex across the whole city – functions as a kind of early twenty-first century *Malleus Maleficarum*³², deriving from ethnographic work a set of explicit instructions for how to assemble a clandestine prostitute out of a series of social, geographical and epidemiological facts.

Despite the enormous complexity of its working practice and the disruptions and discontinuities that had to be managed by clinic staff as bureaucratic definitions of *clandestinité* met the realities of working class lives, the mobile clinic presented a *coherent* study in the sense that the practices which produced the subject *clandestine* were relatively easy to trace in the NGO’s documentary practice and in the super-articulate testimony of the NGO-ethnographers. Following these traces was far more difficult at the Institute of Social Hygiene where the subject (the registered, official “prostitute”) remained stable but became a distinctively “multiple” (Mol, 2002) object of inquiry with the implication of a biomedical research regime with its own strategic goals, sites of operation, and epistemic concerns. At the Institute of Social Hygiene I traced the local politics of enrolment, examining how processes of recruitment and retention were dependent on a continuous transgression across lines of care, experiment, and bureaucracy.

In chapters four and seven I explored issues around working practices and the crafting of the “regulators” professional selves. In chapter three the focus was the historical struggles to define the *difference* of “prostitution” in the neoliberal city dominated by masculine and feminine forms of ruse and “goorgoorlu” (getting by). I argued that a new kind of professional expertise had emerged out of this difficulty – researcher-ethnographers who could ‘recognize’ a prostitute. In chapter seven the focus was the (bio)ethics of regulation as a form of increasingly private and internalized self-writing. In both these chapters I argued that both “care” – warm, interpersonal relationships – and regulatory bioethics should be implicated in projects of power and the perpetuation of

³² The *Malleus Maleficarum* also known as the “Hammer of Witches” was one of the best known medieval texts. It concerned the identification and enumeration of the characteristics and practices of witches and transformed both legal and popular knowledge about witchcraft. According to Hans Peter Broedel: “Prior to the fifteenth century, people spoke in terms of heretics, of maleficium, of monstrous female spirits – the lamiae and strigae, but not of a single composite category “witch” (Broedel, 2003, p. 3).

relationships of inequity. That is to say, I added caring for others and making ethical calculations to the potential repertoire of activities of *triage*.

Experimental Futures

Doreen Massey writes that “imagining space as always in process, as never a closed system, resonates with an increasingly vocal insistence within political discourses on the *genuine openness of the future*” (Massey, 2005, p. 11) outside of the seemingly inexorable grand narratives of modernity. In rejecting the telos of the experimental ethnographies that posit bodies as increasingly caught up in ever widening circles of instrumental relations in a thickening and layering of historical ironies, I have tried to keep hold of agency, discontinuity, and contingency in experimental histories.

It is difficult to know what will happen next to state and non-state regulation in Dakar. The Enda mobile clinic has moved out of the city and the Enda santé have shifted their offices out of Dakar and towards Mbour. This move indicates their decision to decentralize and focus on parts of the country less well served by NGOs – new laboratories for their experimental interventions. Already they have begun mapping new contexts, new vulnerabilities, and drawing up new cartographies of risky sex, practices which will be generative of new knowledges about peri-urban and rural commercial sexualities.

The Natural History of HIV-2 project in Senegal is a remarkable story of twentieth century science, moving as it does from colonial sanitary policy, to the capturing of “modernization” programmes by a postcolonial scientific elite, through “big” transnational HIV science in the 1990s, and, latterly, towards disinvestment, decline and the cobbling together of resources across biological and humanitarian funding strands. Talking to people around the city it seems that many think that the experimental regime has prolonged state regulation past its natural lifespan and that regulation should be brought up to date. However, it is difficult to predict where this experimental regime will go next or what kinds of alliances might be founded in the future. Perhaps a scientific advance will be made elsewhere that will unlock the significance of the serological archive in Dakar, and catapult this small scientific community composed of civil servants, social workers, sex workers and scientists *back* into the scientific mainstream. Once state regulation and humanitarian intervention piggy-backed on scientific funding, it doesn’t seem impossible or improbable to me

that in the future this dynamic will be reversed, and that an NGO who believes they are funding microcredit for unfortunate Senegalese prostitutes might find they have been quietly funding laboratory internships. The system that has been established is robust and the scientists have proved themselves adept at surviving shocks: leveraging and co-opting resources from Family Planning budgets in the 1970s and scientific capacity transfer in the 2000s.

Difference and biopolitics

I have traced these disruptive and unexpected regulatory histories across the last two decades of the twentieth century and up to the present day. However, in this thesis I have also been concerned with analyzing the role of racial, gender, and class difference in the complex socio-technical interventions of late twentieth century sanitary regulation. Sanitary regulation as it is practiced at the end of the century has clearly retained the traces of the colonial system that preceded it – a system based on racial and gender difference which treated women as proxies for a larger biopolitical population and leaving them with the responsibility for assuring the health and future of the nation. However these differences are part of a wider and mobile play of differences across regulatory landscapes which produce complex ethico-ontological constellations of power in the clinics.

In chapter four I examined how differences were woven through the knowing practices of the particular, located subjects who have tried to get to grips with the complexity of Dakar women's affective and sexual lives: colonial bureaucrats, anthropologists and NGO-ethnographers. While the archive contains documents that testify to colonial women in the city being treated as a "radiant source of otherness" (Hook, 2005); the NGO-ethnographies produce highly subtle gradations of differentiation *between* sex workers, writing themselves into the account as expert witnesses mobilising knowledges "in and of the body" and "palpating" a difference that can (only) be seen by the fieldworkers.

In chapter five I developed these themes telling the story of how the Enda mobile clinic won the recognition of the state and received tacit permission to operate on the state's tradition biopolitical terrain. I examined how certain embodiments are produced as legible within the parameters of the given but evolving identity: *clandestine*. In the fieldworkers own practice they do not draw hard and

fast lines between “normal” women and “clandestine prostitutes” – they work with mobile and labile differences; reading gait, tone of voice, and dress as well as body shape and dress. Within their diagnostic strategies there is no centre of gravity, “no point of sameness or neutrality around which all other differences can be organized, hierarchized, or measured”; this is not just “differentiation between variable subjects” but a “movement of emergence that is at the heart of materiality” (Grosz, 2011, pp. 103-104).

In chapter six I told of how I struggled in my research to establish the *difference* of the experimental regime articulated around a “new” molecular form of biopolitics. I argued that “multiple” bodies had emerged through the tracking around and across the cross-hatched spaces of research/regulation/bureaucracy. Difference is linked to experimental instrumentalities, as bodies marked by certain kinds of embodied difference might be considered “disposable” through the practices of colonial and technoscientific “triage” and therefore be at risk of being caught up in instrumental relationships. Answering the question Marilyn Strathern poses about the central problem of instrumentality: “How can we tell the difference between an extension or realization of human capacity and its perversion or subversion?” (Strathern, 1991, p. 43), is not an easy task, even when the case in hand is a micropolitical study of a single site. However in this thesis I have argued for a more nuanced view of instrumental relationships and one which sees processes of instrumentalisation as productive of new possibilities.

As Cheah (2006) argues, the “humanity” of peoples vulnerable to exploitation and instrumentalisation “comes into presence as a result of a complex and sensitive series of negotiations between the mobile, conflicting interests of different forces” (Cheah, 2006, p. 1156). In chapter seven I investigated closely the highly ambivalent effects of the bioethical guidelines that are put in place precisely to protect bodies from instrumentalisation. Paradoxically these processes and protocols have the effect of circumscribing morality as expertise and shutting out potential voices raised in challenge against the clinic. In this chapter I thought about the use of *bioethics* as a set of local discourses and practices which *attempted* to accommodate differences in the clinic and work them through a renewed ethical practice.

While attempts at the Institute of Social Hygiene to foreground and handle differences through the use of bioethics were partly unsuccessful, in this chapter there were moments of *hopeful* connection and possibility, such as the affective connections across the clinic between the research physicians and the seropositive women. I believe that the social lives of the clinics point to at least a possibility of functioning as a plural space in the Arendtian sense. Plurality here is not treated as a synonym for ‘being-with, intersubjectivity or sociality’ , but rather plurality corresponds to a kind of action – “making oneself known through words and deeds” – and these moments of relation and exchange at the clinic work on individual’s capacity to be affected. Similarly, the mobile clinic produces “hard” data out of behavioural ethnographies; entangling women in an identity they do not recognize – the clinic is a story that reminds us that “if subjectivity was never as coherent as we imagine it, it’s not quite so incoherent as we would like it to be” (Grossberg, 1987). However, using ethnomethodology exposes some of the affective terrains of the intervention. Dy Ly quoted in the fieldnote at the beginning of chapter three concluding “*l’individu est complique*” is expressing some of the incommensurable identity work that clandestine sex workers do. If these insights are difficult to fit within the information aesthetic of NGO research, at least they are present and we might be hopeful that they will find another format, another forum, in which to circulate.

While on the one hand my reimagining of biopower and drawing out of its spatial, ethical, and affective dimensions has shown some of the complexities of power relations, the embodied differences that shape them, and the social bodies these differences enable; I remain hopeful that beyond the *historical ironies* of the experimentality ethnographies there is a possibility of new analyses, new interventions and new social bodies attuned to Haraway’s definition of irony: “contradictions that do not resolve into larger wholes, even dialectically”, and which might generate forms of practice which remain committed to the “tension of holding incompatible things together because both or all are necessary and true” (1985: 65).

Conceptual contribution

Empirically this thesis has traced the changes, continuities and new entanglements sketched out above. I also hope to publish this work and to contribute to three major ongoing disciplinary debates. The first is the study of difference in technoscience and the fraught disciplinary dialogues

between feminist cultural studies of science and anthropologies and geographies of science. Science studies is probably the single discipline within which feminist theory has had the greatest reach and influence; research that thinks through the unequal gendered effects of scientific (and pseudo-scientific) knowledge as these effects are lived and experienced is well developed within this field. Far less well developed, however, is work which looks at how gender, race, and location intertwine in transnational science: in other words, how we might build *intersectional* approaches to postcolonial science studies. In this thesis I have tried to think through, for example, the kinds of locally gendered practices that are translated into inflexible public health categories through NGO behavioural ethnographies.

This thesis also makes a distinctive contribution to medical history and to methodological questions in medical history enquiry. I have reflected throughout this thesis on the challenges and the potential of lifting the canonical medical histories of sanitary regulation out of the archives and applying their insights to complex and fast changing presents. Questions of continuities and the colonial present are powerful themes in this text although perhaps more latent than explicit at this stage. I am working on an article for publication which focuses on theorizing the space/time of (post)colonial medicine through an evaluation of alternative conceptual tools: Laura Ann Stoler's "tense and tender ties" (Stoler, 2001) and Peter Redfield's "half-life of empire" (Redfield, 2002), and my own use of the "fold" of the body.

Finally, this thesis makes a strong and original contribution to the feminist critique of bioethics. Staying true to feminist commitments to place, feeling, and women's experience, I have not just "embedded" my study of bioethical reasoning but I have also considered empirical issues of desire, subjectivity and attachment. I see the importance of involving voices currently excluded from bioethical debates and making these debates about more than a private battle of conscience engaged by individual researcher/physicians. However, I have also thought carefully about how ethical subject positions are negotiated and defended within the clinic and I suggest that any analysis of bioethical issues that wishes to be sensitive to entrenched power relations should do the same.

Dissemination of the research material

I am returning to Dakar in April 2012 and while there I will be able to disseminate some of the data that I have gathered and presented in this thesis. At the Institute of Social Hygiene I will make an effort to emphasize the importance of AWA's work. My research has found much evidence that this supportive work is vital. It is clear that the Institute should not become complacent about the importance of peer education and outreach, as women arrive to register all the time with little understanding of the obligations that registration places upon them and the services that are available to them through the clinic. The policy of training a cohort of peer educators has had a very positive effect at the clinic and I will strongly recommend that the work continues and moreover that this work continues to be financed out of the overall budget for research activities.

At Enda santé my research dissemination strategies will involve a small follow up research project. I would like to be able to feed back to the organization data about the current activities of the Dakar groups more than a year after Enda stopped providing support and moved their base of operations to Mbour. Were the women's groups self-sustaining? If some have continued to meet and others have not then what seems to characterize the groups who maintained a support network once the resources had been withdrawn? I hope that this data will allow Enda to reflect upon the difficult questions of legacy, continuity and responsibility - very difficult questions faced by very many non-governmental organizations.

ARCHIVE MATERIAL

Senegalese National Archives
Building Administratif, Avenue Léopold Sédar Senghor, Dakar

1H48/144 Prostitution en AOF 1946-1957

FORMAL INTERVIEWS CONDUCTED

Interviewee	Role	Date	Subjects discussed
“Mamadou”	Enda fieldworker	January 22 nd 2009	History and personal experiences of the Enda mobile clinic
“Oumy”	Enda fieldworker	February 9 th 2009	History and personal experiences of the Enda mobile clinic
“Mariama”	Enda fieldworker	February 10 th 2009	History and personal experiences of the Enda mobile clinic
“Rama”	Enda fieldworker	February 20 th 2009	History and personal experiences of the Enda mobile clinic
“Binta”	Doctor, Enda mobile clinic	February 22 nd 2009	History and personal experiences of the Enda mobile clinic
Ousmane Tabara	Sida Service	?	NGO implication in national level health policy, <i>Projet Ester</i>
Michel Diouf	Sida Service	February 25 th 2009	NGO implication in national level health policy, <i>Projet Ester</i> , testing and treatment regimes across the city
Marieme Soumare	Director, AWA	March 4 th 2009	History of AWA, history of IHS
Peer educators	Sida Service	13 th May 2009	Outreach work, <i>Projet Esther</i> , NGOs
“Rama”	Enda fieldworker	10 th May 2009	Mobile clinic, outreach work in Dakar, interventions in the city
“Oumy”	Enda fieldworker	?	Mobile clinic, outreach work in Dakar, interventions in the city
Peer educators	Sida Service	15 th May 2009	Outreach work, <i>Projet Esther</i> , NGOs
Peer educators	Sida Service	22 nd May 2009	Outreach work, <i>Projet Esther</i> , NGOs
Marieme Soumare	Director, AWA	25 th May 2009	History of AWA, history of IHS, relationship

			between AWA and the clinic
“Mariama”	Enda fieldworker	25 th June 2009	Mobile clinic, outreach work in Dakar, interventions in the city
Daouda Diouf	Director, Enda santé	2 nd July 2009	Enda, history of mobile clinic, future of mobile clinic
“Mamadou”	Enda fieldworker	2 nd July 2009	Mobile clinic, outreach work in Dakar, interventions in the city, testing and treatment at the mobile clinic
Massogui Thiandoum	ANCS	6 th July 2009	Coordination work amongst NGOs, relationship between NGOs and the ANCS
Dr Ndiaye	Doctor, IHS	9 th July 2009	History of the IHS and research work, the natural history of HIV-2, Souleymane Mboup, care treatment and outreach at the IHS, AWA.
Dr Diouf	Doctor IHS	10 th July 2009	History of the IHS and research work, the natural history of HIV-2, Souleymane Mboup, care treatment and outreach at the IHS, AWA.
Head social worker	IHS	21 st July 2009	History of the IHS, legal obligations of regulation, legislation, AWA, difficulties in treating women who arrive at the clinic.
Clinic database technicians	Enda santé	27 th July 2009	Use of the database, relationship between information gathered at the clinic and the NGO.
Michel Diouf	Sida Service	29 th July 2009	NGO implication in national level health policy, <i>Projet Ester</i> , testing and treatment regimes across the city, history of

			HIV intervention in Senegal.
Dr Diouf	Doctor, IHS	?	History of IHS, natural history of HIV-2, ethics, AWA.
“Mamadou”	Enda fieldworker	April 22 nd 2010	History of mobile clinic intervention, future of mobile clinic.
“Rama”	Enda fieldworker	April 25 th 2010	History of mobile clinic intervention, future of mobile clinic.
Daouda Diouf	Director, Enda santé	April 27 th 2010	Enda, history of mobile clinic, future of mobile clinic
Dr Thiam	Doctor, Enda mobile clinic	May 2 nd 2010	History of mobile clinic intervention, future of mobile clinic, clinical challenges.
Dr Ndiaye	Doctor, IHS	?	History of IHS, natural history of HIV-2, ethics, AWA.
Dr Diouf	Doctor, IHS	?	History of IHS, natural history of HIV-2, ethics, AWA.
Mme Soumare	Director, AWA	May 5 th 2010	History of AWA, history of IHS, relationship between AWA and the clinic
Deputy Social Worker	Deputy Social Worker, IHS	May 27 th 2010	History of the IHS, legal obligations of regulation, legislation, AWA, difficulties in treating women who arrive at the clinic.
Fanta Diop	Deputy Director, Enda santé	June 8 th 2010	Enda, history of mobile clinic, future of mobile clinic
Health Assistants	IHS	June 10 th 2010	Challenges of clinical practice at IHS, behavior of registered women, ethics, natural history of HIV-2.

Dr Ibra Ndoye	Director, CNLS	June 11 th 2010	History of biomedicine in Senegal, history of HIV in Senegal, history of CNLS.
Aziz Hane	Laboratoire le Dantec	June 15 th 2010	Natural history of HIV-2, history of laboratoire le Dantec, relationship between lab and hospital. Relationship between work in Senegal and scientific work in rest of West Africa.
Social Worker	IHS	June 18 th 2010	Ethics, past present and future of IHS, behavior of women who register at the clinic.
Dr Niang and M. Mamadou Ndao	Family Health International	June 18 th 2010	FHI, sentinel surveillance, history of NGO interventions in Dakar, history of HIV in Senegal
Nurse	IHS	June 20 th 2010	Daily clinical practice at the IHS, staff and challenges.
Souleymane Mboup	Laboratoire le Dantec	June 23 rd 2010	Natural history of HIV-2, history of laboratoire le Dantec, relationship between lab and hospital.

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