CHAPTER 15

DISEASE, MEDICINE, AND HEALTH

DIEGO ARMUS
ADRIÁN LÓPEZ DENIS

SINCE the 1970s, the historical study of human responses to disease has produced a significant amount of highly influential literature worldwide. Developments in the field have been shaped by (and have contributed to) some of the most radical transformations at the core of the humanities and social sciences. Established disciplines like population studies, history of medicine, and the sociology of public health are evolving to accommodate more aspects of the complex interaction between the sick, health care practitioners, and the society at large. The history of medicine has been enriched by the incorporation of fresh anthropological perspectives on the cultural determinants of health and healing. Scholars working at the intersection of literary theory and cultural studies are acquiring a taste for the historical analysis of biomedical narratives, while social scientists interested in central categories like gender, race, and class are intrigued by multiple connections between medical knowledge, health policy, and identity politics. The role of disease and healing practices in the articulation of geopolitical units at global and local levels attracts the attention of specialists in the history of imperial expansion, colonialism, neocolonialism, modernities and the environment. As a whole, and in no more than four decades, the social and cultural history of disease, medicine, and health became a dynamic source of intellectual renovation in contemporary academic circles.[1]

Like medicine itself, scholarly knowledge about the history of human responses to disease has been circulating along asymmetric channels and passing through multiple colonial and neocolonial filters. The heterogeneous body of historical literature generated through this complex process has been and continues to be shaped

by cultural transmissions, appropriations, and innovations. This essay attempts to present an overview of this fast-developing subfield of historical inquiry, based on thematic units organized along a roughly chronological sequence. Although extremely hard to characterize in general terms, some major patterns emerge from a systematic evaluation of the existent bibliography. First of all, when dealing with the history of health, medicine, and disease in the region, a conventional distinction between "colonial" and "national" periods seems less relevant than a division based on the diffusion of bacteriology—slow and with unequal intensity and success, not only in the rural and urban worlds but also among countries—during the last quarter of the nineteenth century.

Studies on the dynamics of disease and healing in Latin America before the introduction of modern bacteriology are unevenly integrated within global academic trends. Environmental and epidemiological considerations provide a framework for a rich historiography dealing with the impact of disease in the early stages of European colonization and conquest.[2] While this literature discusses the consequences of transoceanic biological integration, a parallel line of inquiry explores other dimensions of early globalization. Developed in relative isolation up to the sixteenth century, multiple healing practices and ideas about disease came together for the first time when peoples from Europe, sub-Saharan Africa, and the Americas collided in the New World. This complex interaction was framed by an array of colonial approaches to sanitary policy and medical practice throughout the hemisphere. Formal institutions for professional supervision, medical training, and hospital care were transplanted from France, Portugal, and Spain to their overseas territories. Guilds, universities, the Catholic Church, and the crown had jurisdiction over most aspects of legal medical practice in these colonies. In the British territories, however, the administration of health matters was relatively decentralized, medical knowledge was typically acquired outside the classroom, and healers operated under less hierarchical arrangements.[3] Although more important in theory than in practice, and keeping in mind the very limited dimensions of the medicalization process during the colonial times, this contrast between formal approaches to health issues in Protestant and Catholic colonies had a great influence on the development of their medical historiography.

Framed by global rather than regional chronologies, most studies on the post-bacteriological or "modern" period are particularly well integrated into worldwide developments in the historiography of the field.[4] However, these features do not translate themselves into globalized or comparative narratives of the history of a certain disease or a certain biomedical process. Instead, the emphasis has been on the local, regional, and national dimensions; only on a few occasions does Latin America emerge as a category of analysis. In any case, and independently of their geographical scope, this historiography results from a research agenda that could be read as the product of two paths of inquiry. The first encompasses approaches that started out with the history of medicine and the biosciences and ended up weaving rich social, political, and cultural narratives and analyses. The second took the opposite path, and departing from broader problems initially defined in terms of society, politics,

and culture, these studies not only discovered illness as an intriguing and contentious historical issue but came to make disease the organizing theme of their historical accounts. It evolved following three historiographical styles that somewhat try to address the powerful interplay among culture, history, medicine, and society. These styles could be labeled as new history of medicine, history of public health, and sociocultural history of disease. Although all these approaches overlap in many respects and see diseases, health, and medicine as settings marked by consensus, tensions, and conflicts, their research agendas are not necessarily similar.

Traditionally, the subject of disease has been a kind of boundary controlled by historians of medicine. They wrote histories of changes in treatments and biographies of famous doctors. Beyond their specific contributions, these histories appear to have attempted to reconstruct the "inevitable progress" generated by university-certified medicine, to unify the past of an increasingly specialized profession, and to emphasize a certain ethos and moral philosophy presented as distinctive, unaltered, and emblematic of medical practice throughout time. The new history of medicine, by contrast, tends to see the development of medicine as a more irregular and faltering process. Engaging in dialogue with the history of science, it discusses the social, cultural, and political contexts in which certain doctors, institutions, and treatments "triumphed," making a place for themselves in history. And it also examines others less successful, which have been forgotten. It strives to understand the natural history of the disease and some aspects of its social dimensions.[5]

The history of public health looks at power, the state, the medical profession, the politics of health, and the impact of public health interventions on mortality and morbidity trends. In general, and to a large extent, this is a history focused on the relations between health institutions and economic, social, and political structures. For some of its practitioners, the goal is to know better certain health-related problems in the past and perhaps inform somewhat the understanding of public health issues of the present.[6] For others, practicing the history of public health is also practicing history in public health, in the sense that they search the past in order to find certain evidence that, they think, can legitimate public health actions and interventions that should shape the immediate and future public health agendas. It is, no doubt, a history that regards itself as useful and instrumental, seeking in the past lessons for the present and future because it assumes that health is an open-ended process.[7]

Thus, the history of public health aims at researching the past in order to reduce the inevitable uncertainties that mark every decision-making process in public health, thereby facilitating in general rather than specific ways interventions in the contemporary scene. To be sure, this approach continues two overlapping legacies, from late-nineteenth- and early-twentieth-century hygiene practice and research and also from certain national histories of public health written since the 1950s. Both efforts, which recognized and underlined the social dimensions of disease, are important antecedents when evaluating scholarship on public health issues from a historical perspective. These, then, are the points of departure for studies which in some cases do nothing more than celebrate the first public health physicians and practitioners and their

actions, much like the traditional history of medicine.[8] In others, writing the biographies of key public health practitioners and policymakers aims more at a critical contextualization than a celebration.[9] Aside from these biographical accounts, other studies attempt to analyze the issue of health and medicine in structuralist code as epiphenomena of the relations of production.[10] Either way, the emphasis of these accounts is on the study of state interventions—or lack of them—to encourage preventive policies and preserve or restore collective health. It focuses on the moments in which the state—based on considerations that go beyond the strictly medical and are shaped by political, economic, cultural, scientific, and technological factors—has promoted actions intended to combat a particular disease.

Most of the time in the history of public health, public medicine appears in a positive and progressive light, as the fortunate outcome of the association of biomedical sciences with a rational organization of society in which certain professionals—public health doctors, above all—offer solutions for the diseases of the modern world. While this association was seen as potentially beneficial, its concrete achievements were found wanting. This unhappy result was presented as a reflection of the dependent condition of the region, without regard for any temporal or national distinctions. According to this approach, this dependency determined the existence of a ruling elite and a structure of economic power that were unable or unwilling to create and distribute public health resources and services in an equitable and efficient manner.[11] Other studies reacted against the schematic use of the dependency model. They summarized the achievements and failures of national or municipal projects aimed at creating or modernizing the basic sanitary infrastructure and reducing mortality. This underlined that, despite the peripheral condition of Latin America and at least in certain countries or cities, the balance was not that negative.[12]

The sociocultural history of disease is more recent than the history of public health. While the latter emphasizes an interventionist agenda aimed at lacking, getting, or preserving health, the former articulates its narrative on the disease as such. It is a history written by historians, sociologists, anthropologists, and cultural critics who have discovered the complexity and possibilities of disease and health, either as problems in themselves or as excuses for discussing other topics. In the first case, and when it is done in its more convincing and sophisticated way, these histories seem to assume—as was stated by one of the most influential historians in this field, who does not study Latin America—that diseases do not exist until we have agreed that they do, by perceiving, naming, and responding to them.[13] In the second, diseases serve broader agendas to understand social and cultural dimensions of the past. This approach barely skims the history of a given etiology; rarely is there any attempt to set up a dialogue between sociocultural history and the history of biomedical science. Instead, it spreads out over topics such as the sociopolitical or sociodemographic dimensions of a particular disease, medical professionalization processes, welfare and social control instruments and institutions, or the state's role in building health infrastructure.[14]

Some of these histories do not go beyond gathering relevant data and basic information. But others, in a deliberate effort to discuss health and disease

problems from a critical perspective, argue for a small set of overriding explanatory factors.[15] At times, these studies tend toward top-down and somewhat conspiratorial explanations: the poor have always been wretched because of a lack of political will on the part of elites and middle classes; every public health initiative resulted from an effort to increase the productivity or guarantee the reproduction of labor; elites got involved in sanitary reforms for their own security; pioneering initiatives were the product of the workings of a new professional state bureaucracy interested in imposing public health measures; or dependent capitalism needed those changes. There have also been Foucauldian interpretations of medicalization, an undoubtedly inspiring line of thinking that has consistently found in medicine and state public health interventions an arsenal of normalizing resources aimed at the consolidation of a modernity that most of the time is vaguely defined and lacking in substantial specific historical references to the place under study. Thus medicine was understood as one of the rationalization enterprises that, having developed particular disciplinary languages and practices, tried to control bodies, individuals, and society.[16] In this context, diseases and medical actions attempting to address them have been seen—quite often overlooking mediations and particularities—as instruments for regulating society, labeling difference, and legitimizing ideological and cultural systems. Finally, there have been ambitious studies in which a certain disease is used as an excuse to discuss broader problems, from metaphors of nation building to literary narratives of the malady, the formulation of public health policies and their consequences, and people's experiences with the disease.[17]

These three lines of inquiry—the new history of medicine, the history of public health, and the sociocultural history of disease—undoubtedly reflect an effort to both build on the empirical information offered by the traditional history of medicine and escape from its limitations. All of them take medicine to be an unstable field where the biomedical is shaped as much by human subjectivity as by objective facts and the medical initiatives are discussed taking into account, not always with similar emphasis, its disciplining and/or progressive dimensions. In a more or less convincing way, all of them try to discuss disease and illness as problems that have a biological dimension but are also loaded with social, cultural, political, and economic connotations. Also, and again with more or less success, these works want to be attentive to the rich mediations between the state, medical knowledge, public health policies, the requirements of the economic system, perceptions and representations of illnesses, and the responses of ordinary people.

In general, the literature on the demographic and social consequences of European conquest has been produced by Anglo-American authors operating on a hemispheric scale to satisfy the needs of a comparative agenda. Studies on the consolidation of healing practices and the socioeconomic impact of disease during the colonial period have flourished in Mexico, a country with a long tradition of scholarly research in fields like medical history, urban demography, and colonial studies. As a result, reconstructions of medico-sanitary developments in New Spain constitute a disproportionately large fraction of the existent literature.

The period between the Spanish American wars of independence and the rise of bacteriology has received only minimal attention. This is not the case for the decades between the 1870s and the 1930s, for which the historiography has been and continues to be particularly prolific. As with other topics, studies on the interplay of disease, health, and medicine for this period reveal many of the similarities and differences that qualify the ways Latin American nations entered modern times. Although most of them shared a neocolonial condition, the processes of urbanization and industrialization did not take place at the same time everywhere, a heterogeneity that is also apparent in the nation- and state-building processes, in the relative position of each nation vis-à-vis multiple and shifting metropolitan references, in the ethnic and racial makeup of national populations, and in the relevance of international migration influences. This diversity of national historical experiences and the many modernities that have been in the making in these decades are clearly present in the historiography of disease and health. Thus, for some countries historians have been focusing their attention on tropical diseases such as malaria, yellow fever, hookworm, and Chagas disease as a consequence of the relevant roles played in the incorporation of the countryside into their national histories—even, at times, as a sort of national pathology. But in other cases, that focus was on diseases and health-related problems such as tuberculosis, syphilis, and urban hygiene, associated not as much with the rural world as with modern city life and industrial growth. Studies focused on the 1940s and 1950s dealing with the expansion of the public health agenda under the populist experiences that marked many Latin American countries are not abundant but are already showing very promising results. Finally, the return of old epidemic diseases such as cholera and the arrival of new ones such as HIV-AIDS during the last decades of the twentieth century are receiving consistent scholarly attention, more by medical anthropologists and public health specialists than by historians interested in the recent past.

The historiographical production for the period from the 1870s onwards has grown in an uneven way. In Brazil, the field has been showing a vibrant and perdurable expansion, with research institutions such as the Casa Oswaldo Cruz–Fiocruz with well-articulated agendas focused on the relations among history, science, technology, health, and biomedicine, excellent academic journals such as *História, Ciências, Saúde—Manguinhos*, ongoing debates, and a steady production of original work resulting from well-established graduate programs and well-organized archives. In the rest of Latin America, even in the large and medium-sized countries, the balance is much more modest, and the resulting picture only highlights emerging networks of researchers, academic journals in process of consolidation, and topics and issues for which there are no more than a handful of works.

In the mid-1960s, a handful of world historians began investigating the complex interactions between biogeography, epidemiology, and sociocultural development. According to these scholars, the European expansion of the sixteenth century could be better understood as a transoceanic exchange of people, crops, animals, and germs, with dramatic consequences at the ecological, socioeconomic, and cultural levels.[18] Opening a new line of historical reasoning, they argued that before 1492 the

aboriginal population of the Americas was free of some of the most common infectious diseases that had ravaged the Old World for centuries. The hardships of early migratory movements through the cold land bridge connecting Asia to North America kept out of the New World many of the vectors and intermediary hosts essential to the spread of mite-, tick-, and mosquito-borne diseases like relapsing fever, schistosomiasis, malaria, and yellow fever. The lack of large herds of domestic animals limited the development of infections such as smallpox, which presumably evolved from centuries of continuous interaction between humans and their cattle. A relatively small population density explained the absence of crowd-related diseases like measles, chickenpox, influenza, and rubella. The Americas were not a disease-free paradise, but having been isolated from Eurasian and African pools of infection, their population had developed a particular set of immunities that made it susceptible to the ravages of many Old World pathogens. Under such circumstances, the first contact with overseas invaders was bound to be deadly for those aborigines lacking most forms of acquired or inherited protection against common European and African diseases.[19]

The notion that differential immunities played an important role in the early colonization of the tropics has been elevated to the category of historical paradigm. Woven together with other evolutionary and technological notions into the so-called guns and germs theories, it appeals to general readers in their search for comprehensive interpretations of the past.[20] Many scholars have been seduced by the explanatory power of this argument and the apparent simplicity of its biomedical foundations. It proved to be particularly useful in redirecting a long-standing debate on the size of the hemispheric aboriginal population before 1492. Wildly ranging from ten to a hundred million, the very existence of these figures represented a challenge for historical demography as a discipline.[21] By accepting estimates on the high end of the spectrum, scholars were automatically compelled to provide an explanation for the implicit demographic catastrophe of the sixteenth century. A series of deadly epidemics was the most obvious candidate to complete the picture, and this in turn encouraged the development of a fertile crossover between the efforts of demographers and historical epidemiologists.[22]

Like many other historical generalizations, this paradigm has been severely criticized. After retracing the genealogy of both lines of research, some specialists claimed that many demographic estimates based upon high mortality rates were the result of epidemiological assumptions regarding the size of the aboriginal populations. From this point of view, the entire model seemed to be based on a circular argument. According to other critics, the basic methodology applied to most estimates of aboriginal population size was mathematically and historically questionable. Most operations were based on a series of progressively distorting multipliers that rendered any result almost meaningless, while the original sources were simply mistranslated, poorly chosen, or misread.[23] Beyond its original generalizations, however, the notion of differential immunities provided a very flexible foundation for more sophisticated evaluations of population dynamics. The very idea of immunity as something that individuals and groups could acquire after a prolonged

exposure to disease allowed this revised version of the model to explain both short-term ecological failure and long-term success. Survival and demographic recovery became legitimate topics alongside more traditional stories of disaster and breakdown, while peripheral regions within the continent received more attention.[24] The inclusion of socioeconomic variables, spatial considerations, and nutritional trends opened the doors of the field to other scholars. Geographers, paleopathologists, paleodemographers, and archeologists contributed a great deal of ecological, dietary, and epidemiological evidence to the reconstruction of early epidemiological dynamics and population patterns in the hemisphere.[25]

In a parallel line of inquiry, other scholars have attempted to clarify the role of differential immunities, nutritional trends, and ecological changes in the development of African slavery in the Americas. Behind these studies is the notion that some African populations enjoyed specific forms of resistance to many Old World pathogens while remaining particularly susceptible to the ravages of other diseases related to their dual condition as slaves and newcomers in the Americas. Some specialists argue that the transatlantic circulation of malaria and yellow fever was a determining factor in the development of the plantation system. According to them, by bringing these and other exotic maladies to the New World, along with their relatively immune human carriers, the first slave traders were in fact replicating the West African disease environment in the Caribbean, Brazil, and the American South.[26] In these particular settings, the relative biological success of people of African descent was so notorious that a combination of natural selection, racial prejudice, and biomedical perceptions fueled new waves of forced transatlantic migration, shaping the final demographic configuration of entire New World regions.[27]

As a complex ecosystem, the plantation depended on a continuous input of labor, food staples, capital, and technology. Under such circumstances, the health of the slaves was severely affected by changes in the composition of their traditional diet, workload, psychological makeup, and reproductive strategies. There is a substantial amount of literature on the living conditions of the slaves and its demographic consequences, with emphasis on the combined effects of malnutrition, exploitation, and infection.[28] Although some scholars overplay the role of ecological and epidemiological factors in the configuration of the plantation system, models based on the interaction of local environments and differential immunities have been useful to explain many significant historical developments in the region, from the outcome of imperial wars in the eighteenth century to the dynamics of smallpox epidemics in colonial Brazil or the cyclical character of Afro-Caribbean religious festivals.[29]

While the biological exchanges triggered by colonization in Latin America can be understood using relatively simple ecological models, studying the complex integration of healing practices that resulted from successive waves of transatlantic migration presents more challenging problems. Peoples from sub-Saharan Africa, the Americas, and Eurasia developed their own responses to disease in a context of relative isolation up until the sixteenth century. Along with its dramatic epidemiological and demographic consequences, the colonization of the New World forced the creation of hybrid healing cultures. Given the nature of the

available written sources, most of the research on indigenous "pre-Columbian" medicine consists in fact of studies dealing, more or less openly, with the early stages of this integration.[30] However, some scholars have produced valuable contributions to the understanding of medical knowledge in the region in their effort to distill some "pure" indigenous or European ingredients from the complex healing practices documented by Iberian chroniclers.[31]

In recent decades, historical, anthropological, and ethnographic research carried out not only among indigenous communities but also on rural or urban communities with a well-defined sense of belonging to what can be called a peripheral and Western world has provided an enormous amount of new evidence regarding the use of natural resources, the cosmological dimensions of healing practices, and the extent to which current beliefs are the result of creative exchanges between traditional and modern forms of medical knowledge.[32] Rather than celebrating folk medicine, these studies explore the transactions that take place between hegemonic and popular knowledge. They emphasize the varied and multifaceted meanings that illness acquires among disparate social, ethnic, or racial groups as well as the importance and complexity of the mutual influences, exchanges, and competition between officially certified, alternative, hybrid, and popular medicines well into the twentieth century. In many cases, particularly from the end of the nineteenth century onwards, this pluralistic scenario has been seen as evidence of the limitations of the process of medicalization or of the broader repertoire of resources available to the sick who used them, in a complementary manner or not, even for goals that go beyond any attempt to get basic care or assistance. That is why the presence of healing practices not controlled by biomedicine is apparent in poorly medicalized societies as well as in others where there were successful medicalization efforts based on universal medical coverage or segmented systems of health care. Of course, and as with many other historical issues, any generalization is problematic. In fact, there are plenty of periods and areas where medical pluralism underlines more pragmatic tolerance than bitter rivalries as well as the other way around, marked by violent encounters between competing medical ideologies.[33]

With the arrival of African slave healers, plantation medicine became another important vehicle for the reformulation of colonial therapeutics. This new wave of practitioners was equipped with a completely different set of healing strategies, embedded in a highly complex cosmology. Their contributions have been explored by historians and anthropologists, but integrating the diachronic and synchronic dimensions of all this research remains a major challenge for the historiography of the field.[34] A promising line of research has been opened by scholars interested in the production of more flexible models for the understanding of medico-religious practices in a context of power asymmetries, renegotiation, and conflict. Mainly for Mexico, but also for other areas of Latin America, there are systematic studies on the sociopolitical and cultural significance of alternative healing in colonial times.[35] These efforts have been based on an imaginative use of inquisitorial records and biomedical literature. Such an approach would be particularly relevant for researchers interested in a reconstruction of the complex channels through which

medical knowledge circulated across the Atlantic. Original sources documenting Iberian colonial contributions to the pharmacopoeia of the Old World have been carefully edited and studied in the last two decades. This material has provided the referential and methodological foundations for a more balanced assessment of early transatlantic exchanges in other biomedical fields.[36]

A long tradition of institutional history based on the rich archives of professional organizations, universities, and hospitals could easily be transplanted from Europe to Latin America. As a result, studies on professional training, medical regulation, and hospital administration were among the first areas cultivated by the pioneers of medical history in Latin America. Today, this type of approach continues to flourish, and some of the most informative literature on the region for the period before the arrival of bacteriology is produced under the aegis of institutional history.[37] Official reactions to disease in colonial times required a high degree of coordination between bureaucratic agents, thus generating huge amounts of paperwork that in turn became valuable sources for the reconstruction of the biomedical past. In recent years, issues like urban sanitation, vaccination, and general prophylaxis have received some scholarly attention.[38]

When dealing with the postbacteriological period, this institutional history acquires not only a quite different tone but also much more density, mainly resulting from the steady (although unequal among and within countries) process of medicalization that took place throughout the twentieth century. On the one hand, there are studies which basically offer raw and very basic information on hospitals, sanatoriums, medical schools, public health government agencies, or philanthropic organizations, but without much effort at contextualization. On the other hand, more ambitious analysis written by social historians, political scientists and sociologists aims not only at reconstructing the emergence of segmented health care networks based on state and civil society institutions, public health state agencies, and international health organizations but also at studying the making and increasing specialization of the medical and paramedical professions, the role played by key public health doctors, the origins of the national social security systems, and the political conflicts and alliances that accompanied the formulation of certain public health policies, sometimes even going beyond the discursive level in order to explore their real impact.[39]

The study of particular epidemic outbreaks and long-term public responses to endemic maladies constitute another important area of historical inquiry in the region. The existing literature on social responses to epidemic disease before and after the advent of modern bacteriology illustrates multiple instances of continuity and change. For the period before the arrival of bacteriology, approaches range from the discussion of specific medical doctrines and public health procedures to the use of epidemics as tools for socioeconomic, ecological, demographic, political, and racial analysis.[40] Although the pandemic and recurrent nature of many outbreaks could provide an excellent opportunity for transnational contrasts and diachronic interpretations, these comparative dimensions of the topic are still uncharted.

For the postbacteriological period, these histories emphasize the social conditions of emergence of epidemics, the reactions of elites and common people, and the role played by state policies and external—colonial or neocolonial—forces combating the outbreaks. Others use epidemics as a way to explore the state of collective health and the infrastructure of sanitation and health care, its role facilitating initiatives in public health and accelerating the presence of state authority, both in social policy and in private life. Less common is a careful examination of the biological and ecological factors present in an epidemic, opening in that way a dialogue between social history and the history of the biomedical sciences.[41] To be sure, the history of epidemics in Latin America adds to a kind of dramaturgy common to all epidemics, interweaving themes of contagion, fear, stigma, blame, salvation, and individual and social responsibility, suggesting on the one hand that continuities seem to be more apparent than changes and on the other that the local dimension should be approached as a chapter of disease history that at least in some cases is global. But this dramaturgy, it is worth stressing, merely defines the framework for an epidemic event, not its specific cultural, religious, or political features. It also does not speak to the ways societies and certain social groups give meanings to the experience of the epidemic, the availability and use of certain strategies and resources for combating it, and the effective implementation of certain general discourses into policies.

In any case, epidemics lay bare the state of collective health and the infrastructure of sanitation and health care and offer a promissing entry to the examination of broader problems. They can facilitate initiatives in public health, and in this way play an accelerating role in expanding state authority, both in social policy and in private life. Nevertheless, society's familiarity with an illness might well lead to ignoring it. This may be either because its persistent presence makes it less extraordinary and surprising, transforming epidemics into endemics, or because the political, social, or geographic contexts in which these epidemics or endemics take place do not allow them to become public, political issues, even though, by definition, they are collective matters.

Before and after the takeoff of modern bacteriology, epidemics were closely associated with urban life, particularly that of great cities. From the end of the nineteenth century until well into the twentieth, this association was also linked to the so-called social question. Thus, with the growing acceptance of monocausal explanations for every illness, references to the larger context were inescapable: the precariousness of garbage disposal, sewer and drinking water systems, housing, biological or racial inheritance, daily habits of hygiene, the work environment, diet and poverty, massive immigration, and the "dangerous" teeming multitudes in the cities. At the beginning of the twentieth century, statistics became a common staple of social analysis, and in some countries state agencies specifically concerned with public health issues were created. First hygienists, and later public health physicians, would play a decisive role in modernizing collective urban facilities and the institutional networks of public assistance, reform, and social control, acting almost as a specialized bureaucracy along with other professionals and political, religious, or governmental agents. At times, the struggle against epidemics took on the character

of quasi-military campaigns in rhetoric, by defining microorganisms as enemies, and, in practice, by encouraging intrusive and violent interventions. Perhaps for that reason, these interventions were resisted on certain occasions, even when their methods were not entirely new to the population. At other times, the larger struggle also included persuasion, aiming to educate the population and disseminate so-called hygienic ways of living.

In certain contexts, diseases like syphilis or leprosy were classified as epidemic even though they did not massively affect the population. They were turned into national problems for social, cultural, or political reasons, legitimated by medical expertise, attracting public attention and spurring campaigns designed specifically to eradicate them. Illnesses, such as cholera, that did not break out suddenly but were well established in everyday life, and sometimes killed and afflicted more people than epidemic diseases, did not always manage to mobilize sufficient material, professional, or symbolic resources to be perceived as national problems. These might be chronic maladies, such as tuberculosis and gastrointestinal diseases, or endemic, such as malaria and hookworm. While less spectacular, these diseases had an impact in cities, the countryside, or both. But because they were more widespread, more difficult to treat, more closely associated with poverty, more socially or geographically distant from centers of power, and more easily overlooked, these diseases could be made visible to public opinion and elite consciousness only with enormous effort, and therefore particular policies to combat them were rare or nonexistent. In the urban world, some of these diseases did manage to become public issues because they came to be seen as part of the "social question" or to be strongly associated with broader national problems.[42] In the countryside, endemic illnesses expanded the area of action of public health interventions, fostering initiatives of rural sanitation that ignited efforts to launch social policies, state expansion agendas, the centralization of power, and, more generally, nation-building processes.[43]

Another relevant topic discussed in some historiographical detail has been the ways in which the state and society confronted disease and health problems. At the core of this topic is the development of public health policies resulting from the interplay between external powers and the emerging of more or less consolidated national states. Here two approaches are apparent. On the one hand, a diffusionist interpretation assumes a clear division between centers and peripheral areas in the production of biomedical knowledge, portraying the latter as passive receptors of knowledge and practices constructed outside the region. On the other hand, a more critical reading of that diffusionism emphasizes not the importing and transplanting of ideas about certain pathologies—yellow fever, malaria, hookworm, Chagas disease—but either the infrequent production of local scientific knowledge or the certainly more relevant and widespread processes of creative selection, assembly, reelaboration, and modification of knowledge produced in the metropolitan centers vis-à-vis the specific, local, and peripheral cultural, political, and institutional contexts. In this interpretive frame, the practices of medical doctors, hygienists, and scientists from the Latin American peripheries are sometimes allied with, sometimes competing against, and sometimes challenging what comes from scientific

and culturally hegemonic Europe or North America. Thus, these studies reveal the existence of a group of Latin American medical professionals actively producing knowledge, debating—before and after the triumph of modern bacteriology—the possible etiologies of certain diseases, creating institutions of scientific excellence, and devoting themselves to more or less original efforts to make a difference in local and regional mortality and morbidity trends.[44]

The politicization of health and the reception and transfer of expertise and practices associated with the fight against malaria, yellow fever, and hookworm have been and continue to be a relevant topic in the historiography. At its core is the role played by some international agencies, in particular the Rockefeller Foundation. Its missions were decisive in the organization of single-disease services and the promotion of technical approaches and specific cures to the detriment of more comprehensive, educational, and preventive strategies. They were also, especially from the 1910s onwards, a proof of the growing presence and influence of the United States as a new metropolitan world player with an increasing hegemonic role in the region. But along with these novelties, what some studies are underlining is that in many countries, small and large, health- and disease-related problems had already become a public issue before these missions arrived. In fact, during the first two-thirds of the nineteenth century, miasmatic and environmentalist approaches dominated medical perceptions of health and disease without producing major changes in the sanitary infrastructure or overall mortality. But toward the end of the century, modern bacteriology took center stage and profoundly shaped the dynamics of many undertakings in public health. It was in this context that some national scientific communities gave greater priority to the study of certain tropical diseases. These doctors, often trained in Western Europe, developed novel and quite specific approaches to research and intervention, sometimes even before their North American peers.[45]

However, the arrival of the Rockefeller missions was crucial in the orientation of sanitary reforms, particularly for rural areas and for diseases which, it was believed, could be eradicated with little cost and in a short time. Despite varied and uneven results in different countries and with different diseases, there is no doubt that the Rockefeller Foundation projects mobilized public opinion, especially with regard to the living and health conditions of the rural poor, contributed enormously to centralizing sanitary efforts, reinforced the power of the central government vis-à-vis the traditional local and regional ones, and consolidated the position of the United States as the dominant external reference in matters of public health. The missions' technical-elitist approaches had to confront the challenge of adapting to the local population's idiosyncrasies and perceptions of specific diseases, particularly in the countryside. This was something that the Rockefeller representatives found as difficult, and did as badly, as most of the native, mainly urban doctors. At the end, what this historiography is trying to underline is that the relations between national and foreign medical groups were complex, at times involving subordination, cooptation, alliance, pragmatism, conflict, or mutual adaptation. In the rural and urban areas, dealing with various diseases, they faced the unavoidable problems of when to interfere in people's everyday routines and customs and when to leave

them alone, and when to use persuasion and when to resort to coercion in order to achieve public health goals. In their original design, missions may have been conceived as purely technical or instrumental endeavors in keeping with a neocolonial philanthropic or economics-based agenda. But when these interventions materialized, they contributed, whether intentionally or not, to establishing precedents and laying the institutional foundations for future preventive medicine projects and, in general, a culture of health that local professional actors would lead and try to disseminate.[46] This scholarship has been the starting point of a new trend of studies focused on global health, international organizations, philanthropic and cooperation initiatives, and colonial and neocolonial encounters rather than global histories of diseases, strongly influenced by and also aiming to influence the relatively new but vibrant field of international and global health.[47]

Studies focused on the sociocultural uses of disease have been in full expansion. Many of them offer historical narratives particularly focused on examining medical discourses on the one hand and the metaphorical uses of disease on the other. Here we see the influence of the Foucauldian interpretative framework shaping studies of madness in general as well as the specific institutions, theoretical systems, and processes of professionalization associated with both the psychiatric order and criminology. Thus, madness has been discussed as a subject that is born and transformed in a field of intersections that range beyond psychiatry itself, and include public hygiene, the spaces of insane asylums, utopian enterprises for collective moral improvement, and the history of nation building and state formation.[48] Some of these pioneering studies have focused on the emergence of a medical power dedicated to disciplining bodies, normalizing general sanitary status, and shaping the political practices of society on an immanent, rather than exterior, level.[49] But quite soon, and as a result of this almost ahistorical tone, they received some criticism. The dominant approaches now tend to be more cautious and more anchored in empirical information, emphasizing both the instrumental and controlling aspects of psychiatry and its humanitarian and liberating possibilities with regard to mental health, and exploring its relations with culture and society at large.[50]

As for the cultural and metaphorical uses of illnesses, an increasing number of studies have explored the connection between literature and disease. The slippery meanings that lie between physical and spiritual disorders and the different written and visual discourses that spiraled around them are at the very core of these interpretative efforts. Many times these interpretations are based on a limited number of texts or sources, read with as much imagination as audacity. Others are the result of more careful exercises of testing these narratives with other sources, exploring and contextualizing the diverse tones as well as the limitations and risks of using the literary register as the only or the most relevant dimension and source at the moment of writing the history of a certain disease.[51]

The struggle against sexually transmitted diseases, particularly syphilis, has also attracted the attention of scholars, who discuss it as part of the effort to construct a population more susceptible to the interests of a certain biopolitics. Implicitly or explicitly, studies of those campaigns seem to have proposed to deal with the sex

drive by self-control and by the rational and conscious assumption of biological responsibilities. Focused in this way, these histories are framed as chapters in the Western civilizing process, which, in the worst cases, end up dissolving or ignoring regional or national specificities. When they do take into account these specificities, historical narratives seek to connect the disease to broader issues such as degeneration, race, immigration, and national identity or to more focused ones such as prostitution and state efforts to control, regulate, or prohibit commercial sex.[52]

In studying the process of concentration of power that doctors acquired as a result of society's increasing medicalization, some scholars have analyzed the emergence of medical models of exclusion based on stereotyping, stigmatizing, and pathologizing behaviors supposedly characteristic of women, homosexuals, and certain immigrant and racial groups.[53] These studies have paid some attention to the complex, porous border between "private" and "public" in public health issues—an especially important question in current studies of AIDS, but obviously also relevant at other times and with other diseases. This porous and ever-changing border is at the very heart of the historical construction not only of health rights as individual and social entitlements but also of more or less ambitious public health state interventions. In line with these concerns, the study of Latin American eugenics has directly touched on the interplay among race, science, medicine, nationalism, and the future of Latin American nations. These issues structured the anxieties of many Latin American intellectuals and physicians between the last third of the nineteenth and first third of the twentieth century. They speculated about the potential contributions as well as limitations of blacks, Indians, mixed-race peoples, and immigrants, and they did so following what they thought were very distinctive national features. The majority of these studies discussed eugenics as a bet not only on social improvement associated with sanitation, education, school hygiene, or matrimonial control but also on racial, ethnic, and immigration selection aimed at building healthy national races.[54] Sophisticated mainly on the discursive level, these histories of eugenics did not explore consistently the making of these social and public health policies, still less their results. Only a very few studies are in dissonance with this dominant historiographical interpretation. Particularly invested in highlighting the violent and racist dimensions of Latin American eugenic discourses, among them sterilization, these studies are not only neglectful of their effective materialization in social policies but also unable to put in perspective what seem to have been no more than marginal voices in the general climate of ideas of those decades. Although more ambitious in scope, some social control studies—focusing partly on medicine but mainly on criminology—should be included in this group as a result of addressing discourses as the only historical dimension, as well as giving (without much evidence) quite weak national states an enormous capability of shaping social life.[55]

The topics of women and children's health, state policies, and public welfare have been receiving increasing attention as well.[56] The way in which these topics have been discussed shares common ground with studies focused on the ideology of hygiene as a means of articulating political concerns in technical terms and the

ideology of public health as an instrument in the nation-building process.[57] Looking at the cultural dimensions of hygiene, some studies have shown how it achieved great social acceptance as a set of values over the medium and long term. Like education, the modern hygienic code seems to have been incorporated into the everyday life of elites and poor alike, regardless of their political or ideological differences. Certainly these social groups, whether in terms of age, wealth, or gender, may not all have had equal access to hygienic practices or have given to hygiene exactly the same meanings. But what these studies tend to underline is the relevance of individual and collective hygiene as a "civilizing" practice not only encouraged and at times imposed from above—from the state to the professional and enlightened elites to the labor leadership to advertising—but also strongly embraced from below, by the common people.[58]

Some studies have explored responses to intrusive and at times compulsory public health efforts. The history of smallpox vaccination reveals layers of social issues that went well beyond this preventive health measure. In fact, while in certain periods and places studies reconstruct a long and ultimately successful process of acceptance of this preventive health practice, at certain junctures this history is marked by individual resistances or even collective and highly politicized revolts. The available literature on this issue offers an array of interpretative approaches, ranging from making sense of these revolts as ways of articulating a sort of moral opposition against the government, to evidences of elite manipulation of popular discomfort, to examples of popular resistance to urban sanitary and health policies, to the behaviors and perceptions of certain racial groups with regard to smallpox control measures.[59] In the case of tuberculosis, some studies explored the ability of the sick to negotiate or even defy medical power. Whether individually, by ignoring its recommendations, or collectively, by organizing strikes, pressuring the political class and using (and being used by) the mass printed media, patients asserted their right to try a treatment and a vaccine that were not approved by the medical establishment.[60] Cancer also motivated the emergence of a social movement aimed at gaining access to drugs patients believed were effective in spite of the negative evaluation of the scientific community.[61] And malaria, yellow fever, and cholera ignited some resistance as a result of public health measures some popular sectors perceived as ineffective or contrary to a mix of indigenous and traditional Hippocratic perceptions about their illnesses.[62] In line with these approaches, other studies tried to introduce voices of the sick using oral history and in so doing are able to begin exploring a very personalized account of the illness experience.[63]

In the end, these studies of the experiences of the sick and their reactions to resources aimed at dealing with diseases seem to point to at least three issues. First, public health interventions and medical practices could be resisted, accepted, or demanded according to local, cultural, social, political, and disease-specific contexts. Second, its impact needs to be discussed in the short and long run, paying attention not only to particular moments of contention but also to the very successful incorporation of these new practices in people's lives, probably less studied and taken for granted because of their success. Finally, it is important to realize the

existence of a degree of historical agency by the sick that reveals that people dealing with diseases are not merely passive objects of medical practices and knowledges. However, the relevance of that agency, especially in the complex process of broadening the meanings of social citizenship and the development of public health policies, should be a subject for careful reflection. In fact, health and disease seem not to have been central to the agenda of the labor movement, nor were they central issues for social movements during the first half of the twentieth century. This relationship can only be made pertinent when health and disease are defined in very general terms, diluted into other labor problems such as the long struggle for shortening the working day, the efforts aimed at improving labor conditions at the workplace, or the development of workers' mutual-aid societies. But it was not until the 1940s that occupational health became a substantial component of the social agendas of the state and organized labor. Still in its early stages, studies on the world of work and disease for that period were perhaps announcing the emergence of what could become a new occupational health history subfield.[64]

The historical agency of the sick and the individual experiences of the illness are also present in studies of HIV-AIDS. In general, the examination of this disease has not been done by historians but by social scientists and medical anthropologists. Since its irruption, the epidemic was initially associated with the homosexual and drug-using communities. Quite soon, this emphasis incorporated poverty as a relevant dimension, and lately a number of international factors that marked Latin American politics during the last third of the twentieth century, such as war, the drug trade, migrations and other global issues, which not only shaped local and national responses from Mexico to Argentina but also unveiled the very diverse—and in comparison with other regions of the world relatively mild—current state of the epidemic.[65]

If for decades after the commercial launch of penicillin in 1945, pathogenic microorganisms seemed finally under control and the great epidemics conquered, only in 1979—a year after the World Health Organization proclaimed victory over smallpox—HIV-AIDS came to the fore as a new deadly infectious disease. Since then, infectious diseases once thought under control, such as tuberculosis, have made a global comeback, and old and never eradicated endemic illnesses such as malaria continue to kill people in the thousands. The scenario is to a certain extent similar to that at the beginning of the bacteriological era, from the 1870s onwards, in which the Pasteurian revolution was speaking of pathogenic microorganisms as invisible enemies to be conquered in the body, just as defensive military battles are a matter of life or death for the social organism. No doubt, then as now, diseases followed not only epidemiological, but also cultural patterns; they were fought using measures of defense and protection, which particularly in epidemic cases always combined both military and hygienic-medical dispositives. In order to understand their history, the historiography of disease, health, and medicine of the bacteriological period has paid attention to the political and cultural logic of these diseases, their mode of action, and social attitudes toward them. Thus, diseases, particularly infectious diseases, were associated with a myriad of phantasms and fears,

and quite often even their medical descriptions were and are structured by metaphors rooted not only in the laboratory but also, and sometimes primarily, in political and cultural traditions.

Discourses about infection feature tiny, invisible, contagious, and uncontrollable organisms as well as transgressions of boundaries through intimate or fleeting contact. Infection supplies a host of metaphors for describing social processes in the language of epidemics. In this current age of increasingly global networking and circulation of people and goods, infection has become the master metaphor. It shapes the emergent political and social discourse of order and its associated technologies of surveillance for controlling borders and immigration. These very contemporary discussions might find in the historiography of disease, health, and medicine not so much a specific blueprint for anti-epidemic political agendas as a sense of how complex the relations among power, society, cultures and medicine were in the past.

This complexity has been the subject of the historiography of the postbacteriological period. The tone of the discussion has been quite plural, with some interpretations strongly articulated around Foucauldian, economistic, institutional, or social-control models of analysis but many more particularly invested in avoiding any rigidity. This effort to move away from determinism is quite apparent in the articles included in a half a dozen anthologies and special issues of academic journals dealing with the region at large or with some of its countries.[66] It is also the case of many studies not only focused on a certain country, city, or disease but also focused on certain health- or disease-specific issues. Worth mentioning as illustrations of these historiographical trends is, for instance, an exhaustive examination of the conditions in which yellow fever was studied and confronted in Brazil when bacteriology was still trying to dominate biomedical thinking.[67] Or books centered on the institutional and political interplay acted out by medical and professional groups, local and national governments, and civil society in the making of the health care systems of Chile, Brazil, and Argentina.[68] Or an ambitious history of medicine in Uruguay that discusses the consolidation of what is characterized as medical monopoly of health care in the context of an emerging new and modern sensibility, all of them topics that for Costa Rica were analyzed highlighting not only the consolidation of the process of medicalization but also the existence of a vibrant and diverse world of popular, alternative, and hybrid healers.[69] For the multicultural Caribbean region and for Revolutionary Mexico, two studies have explored the interaction among international health organizations, local and national public health agencies, and official and nonofficial medicine in the achievements and limitations of the heath care systems.[70] Some books on Brazil, Mexico, Peru, and Bolivia discuss diseases and public health campaigns in very specific settings and for relatively short time periods.[71] In other cases, the emphasis aims at the examination of specific public health campaigns on malaria in Mexico and leprosy in Colombia, but over longer periods of time.[72] And in few instances, such as a study of tuberculosis in Buenos Aires between 1870 and 1950, the goal was to write a total history of the disease (inevitably elusive) in which culture, society, power, and official and

nonofficial medicines are discussed not only as metaphors, politics, and individual and collective experiences but also as problems that exceed the disease itself, ending up metamorphosed into broader historical processes.[73]

The symbolic meanings and social impact of certain illnesses and public health efforts can be properly understood in historical terms only when a broad range of factors are taken into consideration. These include demographic structures and specific epidemiological histories; colonial and neocolonial contexts; levels of urbanization and industrialization; public health and social policies; the agendas and priorities of international agencies and professional experts involved in disease control; and the state of scientific, medical, and technological knowledge and practices. They also can include specific moments of social demands; the politics of nationalism and national self-image; the greater or lesser presence and influence of the mass media in people's lives; broader debates and negotiations between state policies and medical, social, and individual responsibilities; and the political and cultural uses of illnesses. These are some of the most decisive factors explaining how, when, and why diseases and public health interventions are perceived and lived in specific ways. No wonder different diseases have played, over time, different roles at the national, regional, and local levels. No wonder what became relevant in epidemiological terms in one country has no significance in another. And no wonder that even taking into account all these variables, making historical sense of a disease is in and of itself a risky enterprise, given the fact that human well-being and ill-being can hardly be fully captured through the lens of a single illness.

These challenges, perplexities, and possibilities have marked the historiography of this subfield of studies in Latin America. If half a century ago the field was the territory of physicians writing more or less celebratory histories of official medicine, since the 1970s it has become clear that diseases, health, and medicines are not only sites where society, culture, and politics interact in a certain period or time, but also analytical tools to understand the always elusive complexity of the historical experience.

NOTES

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