Race, Class or Culture? The Construction of the European in Colonial Malaria Control

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RESÜMEE

Der Aufsatz untersucht, auf welche Weise Ärzte im kolonialen Kontext den „Europäer" dachten. Er nimmt dafür zeitgenössische Debatten über die Disposition bestimmter „Bevölkerungsgruppen" für Krankheiten wie Malaria und Schlafkrankheit in den Blick sowie die Praxis der Malariabekämpfung in der Kolonie Deutsch-Ostafrika zu Beginn des 20. Jahrhunderts, in der „Europäer" und „Farbige" unterschiedlich behandelt wurden. Es wird gezeigt, wie „Europäer" und „Farbige" als Phänomene konstruiert wurden und immer wieder argumentativ und praktisch voneinander abgegrenzt werden mussten. Am Beispiel der dabei produzierten „Grenzfälle" der „Goanesen" und „Buren" arbeite ich heraus, dass in der Idee des „Europäers" das Konzept biologisch definierbarer „Rassen" auch für Ärzte untrennbar mit Vorstellungen von „Kultur" sowie mit Klasse verknüpft war.

Introduction

Historians of colonialism often face the dilemma of being provided a vast amount of sources left behind by agents of colonialism, while being interested in the perspectives of the colonized. They then need to read documents against the grain in order to discern what Africans, Indians, Filipinos and others might have said, thought or done. Compared to this challenge, this paper's aim, to look for "the European" in colonial sources, may appear a rather comfortable exercise. However, this is misleading: First, authors of colonial reports, while conceiving themselves as "Europeans," rarely did so explicitly. Second, they mostly remained silent about how they defined this category. While they devoted much space to comments on assumed differentiations within the "Coloured population" (*Farbige*) – setting "indigenous Coloureds" (*eingeborene Farbige*) apart from

"non-indigenous Coloureds" (*nicht-eingeborene Farbige*) and detailing whether "Africans," "Arabs," "Sudanese"[1] and so on belonged to one or the other category – defining "Europeans" or the "White population" seemed unnecessary to them. Third, their idea of the European revealed inconsistencies. That colonial officials often used "European" interchangeably with "White" and "Non-Native" indicates one of these inconsistencies, for these were uneasy synonyms – with "White" building on the idea of distinct bodily markers while "Non-Native" referred to a category of colonial law. This inconsistency at times caused some people to be counted as Europeans but only to be reluctantly recognized as Whites.[2]

The use of the term "European" was common for colonial officials as much as for the protagonists of this paper: colonial doctors. Although one might expect the latter to have been interested in drawing clear, biological lines around the European and other "groups" – after all, nineteenth and twentieth century medicine mingled with the racial taxonomies of anthropology and eugenics[3] – doctors were not explicitly concerned with defining the European. Thus, they generally remained elusive on the question of whom and what they understood as such. On the other hand, their writings reveal that they took the existence of the group "European" for granted and that they at least tried to account for its existence by both drawing on medical knowledge and in their day-to-day practice.

Focusing on German East Africa, this paper traces colonial physicians' attempts to delimit the European. It asks which lines colonial physicians drew around the European and which criteria they put forward in order to include and exclude individuals from this category. One can expect biology and medicine to have played an important role in physicians' ideas on the European and the following section will comment on their impact. Yet, physicians in German East Africa were not only medical workers or scientists, but also members of the colonial administration and elite, embedded in structures of colonial rule. How did this impact their idea of the European? How was this concept informed by colonial ideas of culture and of social order? And how were these non-scientific ideas reconciled with medical theories in their imaginations of the European?

I will investigate these questions by concentrating on those physicians who were involved in the control of malaria in German East Africa, from the end of the nineteenth century to the beginning of the First World War. Malaria control and research provide a good

1 I use quotation marks in some cases to emphasize the constructed character of these and other categories. However, even in cases in which I forego this emphasis, I take "European," "Coloureds," "Africans," "Boers," etc. as constructed categories – not as given groups. All translations are by the author.

2 See among others: Reichs-Kolonialamt (ed.), Die deutschen Schutzgebiete in Afrika und der Südsee 1912/1913. Amtliche Jahresberichte, Berlin 1914, pp. 8-12; H. Schnee (ed.), Deutsches Kolonial-Lexikon. Vol. 3, Leipzig 1920, p. 318.

3 On the links between German colonial anthropology, eugenics, medicine and colonialism, see: P. Grosse, Kolonialismus, Eugenik und bürgerliche Gesellschaft in Deutschland 1850–1918, Frankfurt and New York 2000; P. Grosse, Turning Native? Anthropology, German Colonialism, and the Paradoxes of the ‚Acclimatization Question' 1885–1918, in: G. Penny and M. Bunzl (eds), Worldly Provincialism. German Anthropology in the Age of Empire, Ann Arbor 2003, pp. 179-197.

focus for an investigation of the scientific construction of the European, for their practice built upon the idea of biological differences between "groups," thus setting the European apart from others on the grounds that he[4] reacted differently to the disease. However, these ideas were not stable, but subject to constant revision in accordance with social, economic and political realities in the colony. Indeed, physicians' conceptions of the European provide a particularly good starting point for our investigation as they illustrate the tension between scientific classifications on the one hand and social categorization on the other, the struggle to establish a scientific basis and to reify what was essentially socially and politically constructed and negotiated.

For my analysis, I draw mainly on the annual medical reports, compiled and edited by the Colonial Ministry from 1903 to 1914, which are based on reports written by physicians working in the colonies. Far from providing an exhaustive investigation into the construction of the European by colonial doctors, this paper sees itself as a twofold exercise: first as an exercise in critically accounting for what Rogers Brubaker has termed "group-making," that is, in tracing the process from categorization to the enactment of imagined categories in everyday life.[5] Thus, I do not understand "European" as referring to a given group of individuals. Instead, I take it to be a category that had first to be created and then to be enacted and reified in everyday life. Second, this paper sees itself as an exercise in "rethinking colonial categories"[6] such as "race," "colonizer" and "colonized" that are so often taken for granted in research on colonial history. Following the appeal issued by Ann L. Stoler, instead of conceiving of the European as a homogenous, stable and uncontested category, I highlight the ways in which colonial doctors differentiated within this category.

Obviously, this article is also an enquiry on colonial racism. This makes it difficult to do without quoting its language. I am well aware that many terms I quote are highly racist. However, I do so with the explicit aim to critically deconstruct these ideas, as my very aim is to show that, far from being innocent, they are the product of politics guided by the racist project of colonialism. Nevertheless, granting defaming language so much space seems unsatisfactory. I am grateful for suggestions on how to adequately deal with this dilemma.

4 Since I am concerned with "the European" as a constructed category, I understand "it" as being the most appropriate pronoun to refer to this concept. However, in order to provide an easier reading, I chose to use "he" – being well aware of the analytical inconsistency this compromise implies as well as of the fact that the pronoun hides differences, especially of gender, within the imagined group.

5 Here I follow Rogers Brubaker's understanding of "group-making as a social, cultural, and political project, aimed at transforming categories into groups or increasing levels of groupness." Brubaker points out that "a category is not a group. It is at best a potential basis for group-formation of 'groupness.' […] By distinguishing consistently between categories and groups, we can problematize – rather than presume – the relation between them. We can ask about the degree of groupness associated with a particular category in a particular setting, and about the political, social, cultural, and psychological processes through which categories are invested with groupness. We can ask how people – and organizations – do things with categories." R. Brubaker, Ethnicity without Groups, Cambridge/MA 2004, pp.12-13.

6 See the argument in: A. L. Stoler, Rethinking Colonial Categories. European Communities and the Boundaries of Rule, in: Comparative Studies in Society and History 31 (1989) 1, pp. 134-161.

1. Drawing boundaries

"European" was an omnipresent category in German East Africa's medical reports. The reports contained sections on each colony that commented first on the number of medical personnel and medical facilities in the territory, then on the number of individuals treated in the hospitals and medical stations, and finally on case histories concerning different diseases. As a matter of principle, each smaller section was differentiated within – between the initial comments relating to "Europeans" (*Europäer*) and the comments relating to "Coloureds" (*Farbige*) that concluded each section. This differentiation did not always seem necessary to physicians in their scientific publications – often they understood their descriptions as applying to humans in general. However, when they referred to assumed differences in the disposition to disease, "European" generally was one of the categories they alluded to, besides "Coloureds," "Negroes" "Natives" or more detailed terms referring to ethnic differentiations. Occasionally, "White"[7] or "Non-Native"[8] were used as synonyms for "European." However, on the whole, these were exceptions.

Nevertheless, the European was not invented by colonial doctors. Moreover, defining the European was not a main concern of colonial physicians. Rather, "European" was a category that pervaded many domains of German rule in East Africa such as colonial administrative work, politics and law. It designated those who were to be judged according to "Non-Native Law," as opposed to those subjected to "Native Law"; furthermore, it defined those who had access to the main political institutions of the colonial state. Therefore, doctors took "the European" for granted. At the same time, they echoed his construction and reproduced it in their descriptions as well as in their medical practice. This is also true for the dichotomy that accompanied German rule. For however inconsistent definitions of the European were, one of his features was at least obvious: he was defined in an essentially negative way, that is in opposition to an Other – or rather to Others. In German East Africa (GEA), the European's Others were "Farbige," "Coloureds" – for administrators as well as for physicians.

1.1 A crooked line: biology

That medical doctors assumed that the dichotomy of "European" / "Coloured" had a biological foundation comes as no great surprise. For the colonial Philippines, Warwick Anderson has shown that "race" was the category that suggested itself to account for patterns of disease occurrence; medical ideas on racial immunity, Anderson argued, provided a "cognitive framework"[9] that could make sense out of the colonists' disease experience.

7 See among others: Reichs-Kolonialamt (ed.), Medizinal-Berichte über die Deutschen Schutzgebiete Deutsch-Ostafrika, Kamerun, Togo, Deutsch-Südwestafrika, -Neu-Guinea, Karolinen-, Marschall-Inseln und Samoa 1905/06, Berlin 1907, p. 21.

8 O. Panse, Schwarzwasserfieber, in: Zeitschrift für Hygiene und Infectionskrankheiten, 42 (1903), p. 1.

9 W. Anderson, Immunities of Empire. Race, Disease, and the New Tropical medicine, 1900–1920, in: Bulletin of the History of Medicine 70 (1996) 1, p. 101.

In colonial Africa, too, physicians seemed to assume that one way to account for the omnipresence of the differentiation between the European and his Others was to point out the fact that this distinction was reflected in differential dispositions to diseases. This is not only documented for malaria, but also for sleeping sickness and blackwater fever, two other diseases that received considerable attention from doctors in the colony.

Before the terms "sleeping sickness" and "trypanosomiasis" became established for the disease that we today understand as being transferred by the tsetse fly, it had been described as "Negro lethargy," revealing the underlying assumption that it would affect Africans only. French and German medical scientists echoed this labeling by inventing terms that would generally go with a genitive attribute – such as "narcotisme des nègres" and "Schlafkrankheit der Neger" ("Negro narcotism," "Negro sleeping sickness").[10] Until the first years of the twentieth century, the main German manuals on tropical medicine believed that "sleeping sickness is an affliction of the Negro race [that] has never been observed in other Coloureds or in Europeans."[11] Interestingly, although since 1902 physicians agreed on the idea that sleeping sickness was caused by micro organisms termed trypanosomes, and although cases were known in which trypanosomes had been found in the blood of Europeans, this did not lead physicians to diagnose sleeping sickness. Instead, they defined infections with trypanosomes in Europeans as "trypanosomiasis," while they reserved "sleeping sickness" for Africans.[12]

Sleeping sickness' counterpart was blackwater fever. The etiology of the disease was hotly debated at the beginning of the twentieth century. Most medical scientists agreed that it was linked to malaria, and a considerable number believed that it was, more particularly, the result of intoxication by the most popular anti-malaria drug, quinine, usually following irregular or inadequate dosage of the medicine.[13] The disease derived its name from its most striking symptom, the presence of blood in the urine, a result of the deterioration of red blood cells that rapidly weakened the body. A considerable number of those affected succumbed to the disease.[14] According to the medical reports on German East Africa, the highest toll of infections and deaths from blackwater fever concerned "Europeans." While physicians noted that the disease affected "Asians," too, they assumed that it spared "Africans": "it has only been observed in Non-Natives," asserted Otto Panse in

10 S. Ehlers, Trypanosomen transnational. Europäisch und afrikanisch in den internationalen Schlafkrankheitsforschungen vor dem Ersten Weltkrieg, Unpublished Magister thesis, Berlin 2009, p. 52.

11 B. Scheube, cited in Ehlers, Trypanosomen (see note 10), p. 53. All translations by the author.

12 Ehlers, Trypanosomen (see note 10), pp. 55-56.

13 R. Koch, Aerztliche Beobachtungen in den Tropen. Vortrag, in: Deutsche Kolonial-Gesellschaft. Verhandlungen, 7 (1898), pp. 301-303; J. Schwalbe (ed.), Gesammelte Werke von Robert Koch, Leipzig 1912, pp. 337-338.

14 The medical reports for German East Africa indicate that around 5 per cent of "Europeans" infected by blackwater fever died of it. See among others: Kolonial-Abteilung des Auswärtigen Amts (ed.), Medizinal-Berichte 1904/05, p. 89; Reichs-Kolonialamt (ed.), Medizinal-Berichte 1909/10, p. 213; Reichs-Kolonialamt (ed.), Medizinal-Berichte 1910/11, p. 351; Reichs-Kolonialamt (ed.), Medizinal-Berichte 1911/12, p. 234.

1903;[15] others assumed that, at least in some regions, "[t]he Negro race enjoys, if not a complete, then at least an extensive immunity against it."[16]

Regarding malaria, things were more complicated: while around 1900 a consensus had been reached on the idea that malaria was caused by micro organisms (*plasmodia*) and transmitted by the anopheles fly, a variety of questions triggered hot debates, which rarely led to a consensus. One of these questions was how to explain the differential occurrence and course of malaria in humans. Physicians occasionally put forward the idea that Africans were endowed with complete immunity against malaria; evidence against this assumption, however, was so obvious that the idea had to be revised. The theory of complete racial immunity was rejected,[17] but medical reports still suggested that "Coloureds" and "Negroes" in particular were less seriously affected by the disease than "Europeans": "Indeed, there seems to exist a difference between the races in favour of the Negro race,"[18] noted Hans Ziemann in his handbook on malaria. Whereas malaria was presented as a highly visible and often fatal infection for "Europeans," it was conceived as a latent and minor one for "Coloureds" and "Negroes." The idea was that "Negroes" might have "by birth been endowed with a certain degree of immunity,"[19] and that even if this was not the case, they must be able to *develop* a certain degree of immunity during the course of their lives, while it remained open to debate whether the same applied to "Europeans."[20]

However, drawing clear lines between Europeans and Others was not easy. Indeed, while it might come as no surprise that physicians attempted to account for differences between these categories by identifying biological differences, it is striking how reluctant they were to abandon such an undertaking, as their assumptions were repeatedly contradicted. From 1903 onward, the idea that sleeping sickness was an "African disease" was openly contested. In December 1903, the *British Medical Journal* published a report titled "Sleeping Sickness and Trypanosomiasis in a European: Death: Preliminary Note." The article caused a stir in the medical world as it presented evidence that "trypanosomiasis" in Europeans and "African sleeping sickness" constituted the same disease. The author of the report was Patrick Manson, one of the United Kingdom's stars of tropical

15 Panse, Schwarzwasserfieber (see note 8), p. 1.

16 This is what Friedrich Plehn, for instance, assumed for German Cameroon, although he acknowledged that cases of blackwater fever in "Negroes" had been observed in other territories. F. Plehn, Die Kamerun-Küste. Studien zur Klimatologie, Physiologie und Pathologie in den Tropen, Berlin 1898, p. 105.

17 Robert Koch, for instance, clearly stated: "There exists no human race which as a matter of principle is immune [to malaria]." Koch, Aerztliche Beobachtungen (see note 13), p. 341.

18 H. Ziemann, Malaria, in: C. Mense (ed.), Handbuch der Tropenkrankheiten, Vol. 5, 1, Leipzig 1917, p. 277.

19 Koch, Aerztliche Beobachtungen (see note 13), p. 342.

20 While for Friedrich Plehn it was clear that in order to explain malaria infections of "Negroes," one had to consider that they could develop an immunity against the disease when regularly exposed to it, he was much more cautious to apply this idea to Europeans. He argued that for Europeans, too, "a certain degree of local acclimatisation without any doubt has some importance". However, it did not occur to him to treat acclimatization of "Europeans" and "Negroes" as one and the same issue. Instead he devoted separate sections to the issue. Interestingly, the section including Europeans was titled "Individual disposition," while the one referring mainly to "Negroes" bore the title "Racial disposition." Plehn, Kamerun-Küste (see note 16), pp. 81-84.

medicine. The report's protagonist was "Mrs. S.": Mrs. S. had been the wife of a missionary working in the French Congo. In late 1901, an insect had bitten her on her left leg, the spot had become infected, and she thereafter had contracted a fever. On return to England, Patrick Manson at the London School of Tropical Medicine examined her. Manson diagnosed an infection with trypanosomiasis and prescribed a therapy with arsenics, the only cure known at the time, to provide at least some relief from the disease. However, Mrs. S. did not recover; instead Manson and his colleague, George Carmichael Low, who observed her condition over the course of one year, identified the classical symptoms of sleeping sickness. An autopsy conducted on the day she died in 1903 confirmed the scientists' late diagnosis.[21]

In the case of Mrs. S., physicians' attempts to cling to the difference between the European and the African by differentiating between supposedly European trypanosomiasis and African sleeping sickness became obsolete. In the following years, more and more cases of sleeping sickness in Europeans would be described in medical journals.[22] The biological line between the European and his African Other was severely blurred.

Blackwater fever met a similar fate. If, at some point, the affliction of blackwater fever had provided a boundary along which the European could be separated, if not against Coloured people in general, then at least against the African in particular, physicians now had to admit that "an absolute immunity to blackwater fever cannot be found in any race."[23] Indeed, several scientists as well as the medical reports on the German colonies reported cases of "blackwater fever in Negroes."[24]

Here again, the boundaries around the European were blurred. For medical scientists, this meant that they had to adjust their statistics. But it had more serious implications, too. The extraordinary attention Manson and Low devoted to one single case of sleeping sickness in a European reveals their uneasiness towards the idea of blurred boundaries, as well as the physicians' reluctance to accept the new evidence of blackwater fever in "Africans." Cases concerning "Africans" or "Natives" (*Eingeborene*) continued to arouse physicians' interest – such as that of Dr. Heinrich Ollwig in Dar es Salaam, who regretted that the only case of blackwater fever concerning an "African" had not been well documented before the sufferer passed away.[25] Also, the often-awkward conclusions on the issue reveal an unwillingness to break completely with the initial theory. Hans Ziemann in his compendium on the issue summarized statistical findings on blackwater fever in "Americans," "Europeans" and "Negroes" in a rather roundabout way. He noted: "Thus,

21 Ehlers, Trypanosomen (see note 10), pp. 56-59.

22 Ibid., p. 58; see also Sarah Ehlers' thorough analysis of the construction of the European in reports on sleeping sickness: Ehlers, Trypanosomen (see note 10), pp. 84-90.

23 H. Ziemann, Schwarzwasserfieber, in: C. Mense (ed.), Handbuch der Tropenkrankheiten, Vol. 5.1, Leipzig 1917, p. 495.

24 Reichs-Kolonialamt (ed.), Medizinal-Berichte über die deutschen Schutzgebiete Deutsch-Ostafrika, Kamerun, Togo, Deutsch-Südwestafrika, -Neu-Guinea, Karolinen-, Marshall-Inseln, Marianen und Samoa für das Jahr 1909/10, Berlin 1911, p. 116; other cases are mentioned in the same report on pp. 117 (German East Africa), 288 (Cameroon); Hans Ziemann provides a review of publications that mention cases of blackwater fever in Africans: H. Ziemann, Schwarzwasserfieber (see note 23), pp. 495-496.

25 Reichs-Kolonialamt (ed.), Medizinal-Berichte 1905/06, pp. 39-40.

we observe the remarkable relative sparing of the Negro race."[26] Although the idea of an absolute immunity had been replaced by that of different degrees of disposition to the disease, "race" still provided the line along which these dispositions were explained. Thus, to Ziemann, the degree of "the single races' share [in blackwater fever]" (*Beteiligung der einzelnen Rassen*)[27] still seemed worth commenting on. Dissolving the categories "European" and "Coloureds" was not on the agenda.

The question of differential dispositions to malaria, finally, had from the start been and remained a controversial issue. However, at least in some German colonies,[28] a growing consensus seemed to develop on the idea that Non-Europeans, too, suffered considerably from the disease, even though reports continued to devote by far the most space to comments on malaria affecting Europeans.[29]

Thus, in medical research, the European was constantly created and dissolved again: evidence revealed that he was not anymore the sole victim of malaria; neither did his affliction with blackwater fever set him apart from the African, nor was he immune against the allegedly "African" disease of sleeping sickness. Medical scientists struggled hard to present straightforward biological accounts of the European. But repeatedly, they had to realize that biology did not provide a reliable basis for stable boundaries.

1.2 Straightening the line: medical practice

However unstable the boundaries were in medical theory, medical practice promised to strengthen them, for it had the power to enact and enforce desired categories, to make them relevant in everyday life, or in Rogers Brubaker's words, to transform categories into groups.[30] The practice of malaria control, as we shall see, did this by administering differential treatment to German East Africa's population.

The European: the main concern of health policies

When in the 1890s medical facilities for civilians began to be established in German East Africa by the colonial administration, it was taken for granted that it was necessary to differentiate between medical service for "Europeans" and for "Non-Europeans".[31] When

26 German original: "Wir sehen also das außerordentlich relative Verschontbleiben der Negerrasse." H. Ziemann, Schwarzwasserfieber (see note 23), p. 496.

27 Ibid., p. 495.

28 In Cameroon, for instance, physicians pointed out that Africans often suffered from malaria as well as from spleen pains accompanying the disease. In contrast, physicians in German East Africa seem to have maintained their virtually exclusive focus on European health. See among others: Eckart, Regierungsärztlicher Bericht für die Zeit vom 1. April bis 30. Juni 1911, Ebolowa, 12.7.1911, in: Archives Nationales de Yaoundé FA 1/877, p. 243.

29 See among others: Kolonial-Abteilung des Auswärtigen Amts (ed.), Medizinal-Berichte 1904/05, p. 24.

30 Brubaker, Ethnicity (see note 5), pp. 12-13.

31 In the following, I deal with facilities established by the colonial government only – not with the system of health care that missions introduced to German East Africa, since this was explicitly aimed at serving the colonized population. For this, see among others: W. U. Eckart, Medizin und Kolonialimperialismus. Deutschland 1884–1945, Paderborn 1997, pp. 354-386.

it was decided to establish a governmental hospital in Tanga, an important coastal base of the colonial administration, discussion arose on several issues, such as whether the building, which had previously been used as a hotel, was adequate for a hospital. But it was taken as a matter of common sense by both officials and physicians that "Europeans" and "Coloureds" had to be accommodated and treated in separate sections. Thus, the first floor was reserved for "Europeans" while "Coloureds" were to be put on the ground floor. For the rooms on the first floor "6 beds including mosquito net"[32] were requested, whereas for the ground floor "12 simple wooden mats"[33] were considered sufficient.

This pattern of segregation was applied to the governmental medical service in general: in Dar es Salaam, the colony's main port and its capital since 1889, the governmental hospital served "Europeans" only, while "Coloureds" were supposed to be treated at Sewa Hadji Hospital.[34] Moreover, the sanatorium opened in September 1904 in the Usambara Mountains in the north of the territory was reserved for the recovery of "Europeans" only.[35]

Clearly, the European was privileged, but most importantly, he was the one whose health was the main concern of medical policies. The main objective, stated the medical report for 1909/10, was to "create bearable conditions in the coastal stretches in which Europeans need to stay permanently"[36] as well as to rid and keep those stretches of land that had been reserved for European settlers free from disease, mainly in the northern parts of the territory. The aim to secure the European's health was linked to the conception of the European as constantly threatened by disease. This was, as the case of malaria control in German East Africa will illustrate, the main attribute with which the European was endowed and which served to set him apart from his Others which were in contrast conceived as threats.

Malaria control: the European as threatened by disease

An overall plan for controlling malaria in German East Africa did not exist. Usually, the physician in charge of a certain region would autonomously decide which measures were to administered, selecting from a wide range of possibilities. In most places, authorities aimed to reduce the amount of stagnant water which was believed to provide breeding places for anopheles mosquitoes. For the same reason, bush was cut down in other regions, the use of quinine as a prophylaxis against malaria was also encouraged, and blood testing was utilized in order to identify individuals infected with malaria and to treat them afterwards.

32 Plehn to Wissmann, Tanga, 18.11.1895, in: TNA G5/4, p. 12.

33 Ibid.

34 The hospital had been financed by the Indian trader Sewa Hadji, who had also given the institution his name. See for instance: Kolonial-Abteilung des Auswärtigen Amts (ed.), Medizinal-Berichte 1904/05, p. 9.

35 Ibid., 12-16; Kolonial-Abteilung des Auswärtigen Amts (ed.), Medizinal-Berichte 1905/06, pp. 17-20.

36 Reichs-Kolonialamt (ed.), Medizinal-Berichte 1909/10, p. 40.

Dar es Salaam and Tanga were the only places in which malaria control schemes were established that claimed to operate systematically. The Dar es Salaam program started in 1901, its pendant in Tanga four years later, and both followed the same rationale: the cities were divided into working districts (in Dar es Salaam five bigger or 22 smaller sections respectively; in Tanga three sections) in which the medical staff would assess the prevalence of malaria by regular visits which would allow them to collect blood samples from inhabitants. Those individuals whose blood samples tested positive for malaria parasites at the hospital lab would be registered as infected and administered quinine treatment and medical post-treatment. After the Dar es Salaam scheme had been heavily criticized as ineffective, it was terminated in 1912. Later attempts to prevent malaria focused on mosquito control through nets, larvicide and the drainage of swamps. The campaign in Tanga had the same fate, being discarded as ineffective shortly before the outbreak of the First World War.[37]

To clame that medical staff collected blood samples from "inhabitants" of Dar es Salaam and Tanga is imprecise, for only those listed as "Non-Europeans" were submitted to blood tests. Admittedly, the Dar es Salaam malaria commission not only toured districts inhabited by Africans and Asians, but also included the European part of the city. The main concern here, however, was not with administering quinine to Europeans but with the danger thought to emanate from the "Europäerboys," local men employed as domestic workers in European homes. Since anopheles mosquitoes were frequent in the district inhabited by Europeans and thus malaria could be transmitted to Europeans, if only the flies were provided with infectious matter, Dr. Robert Kudicke, the physician supervising the malaria campaign after 1905, concluded:

> *[A]lso among Europeans, even under favourable climatic conditions, [malaria] infections will continue to occur, as long as no effort is made to ban the Coloureds from the European quarters.*[38]

This reasoning depicted Coloureds as those providing the "infectious matter," as carriers of disease and the source of infection; Europeans, on the other hand, figured as the disease's victims. Mosquitoes were conceived of as the link between the source and its victim.

As has been noted, around 1900 medical scientists had agreed on the premise that the transmission of malaria parasites from one human to another was only possible through the bite of the anopheles mosquito. What physicians described was a cycle of infection roughly following the pattern "(parasite in) human <> (parasite in) mosquito <> (parasite in) human <> (parasite in) mosquito" and so on. The cycle could be described as starting either with "(parasite in) human" or with "(parasite in) mosquito" and ending with one of the two stages – this did not affect the cycle's structure.

37 A. Beck, Medicine and Society in Tanganyika 1890–1930. A Historical Inquiry, Philadelphia 1977, pp. 15-16; D. F. Clyde, History of the Medical Services of Tanganyika, Dar es Salaam 1962, pp. 16-45.

38 Kolonial-Abteilung des Auswärtigen Amts (ed.), Medizinal-Berichte 1904/05, p. 31.

The practice of malaria control, however, reveals that this conception of the cycle had been transformed. The omnipresent categories "European" and "Coloured" were integrated into the cycle of infection. In fact, it was no longer a cycle, but was molded into a chain with a clear starting point and, more importantly, a clear end. At its beginning stood the cause of infection and at its end the alleged victim of infection, the European. At the same time, just as "human" was equated with "European," the "parasite" or cause of infection was equated with "Coloured." The chain of infection thus followed the pattern: "Coloured > mosquito > European."
This reasoning pervaded physicians' concerns. Not only did Dr. Kudicke warn that Europeans would only be freed from malaria when their domestic workers had been banned from the European residential areas. He furthermore pointed out that the increase in malaria infections among Europeans in 1905 was due to the fact that the curfew imposed on Africans had been abolished at the beginning of the year, with the effect that they "had been allowed full scope to move also at night, thus favouring the spread of malaria."[39] The notion of Africans and Coloureds constituting the sources of infection was not merely something people talked about: the measures initiated against malaria were in perfect accordance with this idea. With the exception of one year, blood tests in Dar es Salaam and Tanga were taken from those defined as "Coloureds" only, while "Europeans" were not examined. Moreover, whereas "Europeans" were only *advised* to take quinine both as a prophylaxis and for treatment, "Coloureds" found to be affected by malaria were not left to decide for themselves, but instead were submitted to compulsory treatment with quinine and to subsequent monitoring of the treatments' results through repeated blood tests. From such a policy, physicians expected quick improvements in Europeans' health conditions. One of them described its effects upon the rural area of Bismarckburg (today Kasanga) south of Lake Tanganyika as follows:

> *All Coloureds who slept at night at the boma* [military camp] *near the European quarters were, during the rainy season, submitted to severe quinine surveillance* [Chininkontrolle] *(every 10th and 11th day they received 1.0 g of quinine each), which may be the reason why neither a boy nor a European contracted malaria*.[40]

There was hardly any difference between trying to render harmless "the Coloureds" or the parasites.[41]

39 Ibid., p. 28.

40 Kolonial-Abteilung des Auswärtigen Amts (ed.), Medizinal-Berichte 1903/04, p. 30.

41 Many historians of medicine have shown that early 20th century medicine and bacteriology in particular provided ideas of infection and contagion that could be used as metaphors in campaigns against political and social enemies. See for instance: P. Sarasin, Die Visualisierung des Feindes. Über metaphorische Technologien der frühen Bakteriologie, in: Geschichte und Gesellschaft, 30, 2 (2004), pp. 250-276; P. Weindling, A Virulent Strain. German Bacteriology as Scientific Racism, 1890–1920, in: W. Ernst and B. Harris (eds), Race, Science and Medicine, 1700–1960, London (1999), pp. 218–234; C. Gradmann, Unsichtbare Feinde. Bakteriologie und politische Sprache im deutschen Kaiserreich, in: P. Sarasin, S. Berger, M. Hänseler, and M. Spörri (eds), Bakteriologie und Moderne. Studien zur Biopolitik des Unsichtbaren, 1870–1920, Frankfurt a. M. 2007, pp. 327-353.

Creating boundaries

Malaria control did not invent the distinction between “Europeans” and “Coloureds”. However, the practice of malaria control confirmed, reproduced and enforced these distinctions by supporting them with arguments of disease control. Thus, according to medical reasoning, Coloureds and Europeans had to be separated in order to prevent the latter from being infected. However, there was more to the argument than the threat of disease. Studies of medical segregation in colonial Africa have shown that the impetus for creating physical distance was closely linked to concerns about social distance.[42] Malaria control in German East Africa, too, reveals this concern. Here, not only were Coloureds pathologized, but so, too was the breaching of boundaries between Coloureds and Europeans. Heinrich Ollwig, the doctor supervising the Dar es Salaam anti-malaria operations, illustrates this poignantly when commenting on the death from malaria of an eleven-year-old “European” boy,

> *who, after the sudden death of his father let himself go* [verwahrloste] *and dealt only with Negro boys with whom he often ate, too, and in whose huts he even stayed in the evenings.* […] *In his blood and in the capillaries of his brain numerous malaria parasites were found. We can definitively assume that his infection occurred in one of the Negro huts.*[43]

One could argue that either the Coloureds “themselves constitute a degenerate race or it is their presence and contact with them or indeed their condition itself which constitutes a crucible of degeneracy,” to borrow from Etienne Balibar’s description of (class) racism.[44] Typically, reports on Europeans suffering from malaria in German East Africa provide details on the place of infection and even note the assumed date of infection.[45] Interestingly, in the case of the European boy, Ollwig abandoned such a detailed reconstruction of the events. From his perspective, the main cause of the boy’s death was that he had dared to blur the boundaries.

The case of the European boy points at something else: the boundaries between the European and his Others were not given. They were above all desired boundaries that had to be created, constantly enacted and reproduced. One way of creating such boundaries was to divide Dar es Salaam into working sections and to adjust this division to assumed

42 See especially: A. Wirz, Malaria-Prophylaxe und kolonialer Städtebau. Fortschritt als Rückschritt?, in: Gesnerus, 37 (1980), pp. 215-234; and also: J. W. Cell, Anglo-Indian Medical Theory and the Origins of Segregation in West Africa, in: The American Historical Review, 91 (1986) 2, pp. 307-335; S. Frenkel, J. Western, Pretext or Prophylaxis? Racial Segregation and Malarial Mosquitos in a British Tropical Colony: Sierra Leone, in: Annals of the Association of American Geographers 78 (1988) 2, pp. 211–228; O. Goerg, From Hill Station (Freetown) to Downtown Conakry (First Ward). Comparing French and British Approaches to Segregation in Colonial Cities at the Beginning of the Twentieth Century, in: Canadian Journal of African Studies, 32 (1998), pp. 1-31.

43 H. Ollwig, Bericht über die Thätigkeit der nach Ostafrika zur Bekämpfung der Malaria entsandten Expedition, in: Zeitschrift für Hygiene und Infectionskrankheiten, 45 (1903) 3, p. 430.

44 E. Balibar and I. Wallerstein, Race, Class, Nation. Ambiguous Identities, London and New York 1991, p. 209.

45 For instance: Reichs-Kolonialamt (ed.), Medizinal-Berichte 1909/10, p. 29, 37, 39.

differences of culture, architecture and lifestyle. Consequently, according to the physician in charge of the malaria program, "working section A" consisted of the "European quarter" and contained massive buildings such as the military camp, the prison, the catholic mission, etc. – while "working section D," hosting a "mainly Negro population," showed a "maze of mud huts that revealed more or less unclean courtyards in between." "[W]orking section E" finally, was made of "a jumble of compounds inhabited entirely by Negroes."[46] The description reveals three interesting points. First, ideas of race and racial boundaries were built on ideas of "culture." Second, the listing followed and at the same time reiterated political and social hierarchies, with the "European quarters" on top of the list and the "Negro quarters" at its bottom. It would have been as plausible to begin the description with the "Coloured quarters." to continue on the "Negro quarters" and to end with the "European quarter." In this way, even a seemingly innocent description of medical working sections helped to reify desired groups and boundaries. Third, as this description provided the basis for medical practice, medical personnel enacted these imagined boundaries by touring the city.
However, as the case of the eleven-year-old boy illustrates, not all attempts to build up and enact boundaries in the colony were successful. The following sections take a closer look at these limitations.

2. Boundaries blurred

From a physician's point of view, "Europeans" were those whose health had to be protected, while "Coloureds" were the ones who threatened Europeans' health. While it is clear that the line was drawn between victims and sources of disease, who exactly was standing on which side of the line, who was counted as European and who was not, remained elusive. Indeed, defining victims and sources was not always a straightforward business. Two examples of what might be called "borderline cases"[47] will illustrate this.

2.1 "Goans"

In German East Africa, "Goans" (*Goanesen*) were conceived of as being associated with the Portuguese colony Goa on the Indian subcontinent. The annual report for 1912/13 listed Goans in the section on "White population" and detailed:

> *these* [Goans] *are partly half casts of today's Portuguese and Indians, partly descendants of such half casts from the former height of Portuguese rule in India (Goa, Ormus, Diu, Daman, etc.), partly descendants of these Goans themselves, again mixed with Indian blood.*[48]

46 Kolonial-Abteilung des Auswärtigen Amts (ed.), Medizinal-Berichte, 1904/05, p. 26.

47 See Dominik Nagl's notion of „Grenzfälle": D. Nagl, Grenzfälle. Staatsangehörigkeit, Rassismus und nationale Identität unter deutscher Kolonialherrschaft, Frankfurt a. M. 2007.

48 Reichs-Kolonialamt (ed.), Schutzgebiete 1912/13, p. 8.

The administration counted only very few "Goans": for 1902, they listed 205 individuals in this category for the whole territory, observing that over half of them lived in Dar es Salaam; in 1913, 656 Goans were counted. Goans were described as working as traders and petit businessmen who mainly served the European market. Portuguese names were considered as being one of the Goans' typical markers, as was the adherence to Catholicism and the adoption of Western habits. Individuals counted as Goans observed the same rights and political privileges as did those counted as Europeans or Non-Natives – as opposed to those subject to Native Law (*Eingeborenenrecht*). They also had access to some institutions of political representation such as the district councils (*Bezirksräte*) administering communal funds and the government council (*Gouvernementsrat*) advising the colonial government. Yet, in reports and address books, Goans were frequently listed as "Indians" or "Asians," who fell under Native Law.[49]

This controversial status was reflected in medical reports. While the annual medical reports for German East Africa, clearly following the all-pervading dichotomy, first dealt with the health of "Europeans," then with that of "Coloureds," it occurred that the category "Goans" figured in both sections. In part, this might have been a matter of organizing statistics, but it reflected an inconsistency in treatment, too: The medical report for 1903/04 for instance documents that Dar es Salaam's hospital treated some individuals termed "Goans" in the Europeans' section and others in the part reserved for Coloureds. Similarly, in 1906/07, a small number of Goans is again said to have been treated in the European section of Dar es Salaam hospital, while in the Tanga hospital, Goans are reported to have been treated in the Coloureds' ward.[50]

Other evidence suggests that physicians classed "Goans" equal to "Europeans": They took it for granted that Goans contracted blackwater fever[51] – while, as has been shown, they considered cases of this disease in "Africans" as highly exceptional. Thus, Goans were considered as contracting the same diseases as Europeans. They were also granted "European" treatment: For the first years of the Dar es Salaam malaria campaign, it was reported that while Coloureds had been administered quinine pills, "Europeans and Goans" had received quinine injections – "according to the wish of those who were hindered in their work because of side effects of the quinine treatment."[52] Most importantly, the Goan was treated as the one whose health, too, had to be secured: on one hand, when Ollwig detailed which measures against malaria would apply to which "groups," he counted Goans among the "Asian population"; on the other hand, he exempted them from those measures which he had reserved for "Indians" and all

49 H. Schnee (ed.), Deutsches Kolonial-Lexikon. Vol. 1, Leipzig 1920, p. 742; J. Becher, Dar es Salaam, Tanga und Tabora. Stadtentwicklung in Tansania unter deutscher Kolonialherrschaft (1885–1914), Stuttgart 1997, pp. 141-142; J. Iliffe, Tanganyika under German Rule. 1905–1912, Nairobi 1973, pp. 112-115; J. Iliffe, A Modern History of Tanganyika, Cambridge 1979, pp. 148-149.

50 Kolonial-Abteilung des Auswärtigen Amts (ed.), Medizinal-Berichte 1903/04, p. 7-10; Kolonial-Abteilung des Auswärtigen Amts (ed.), Medizinal-Berichte 1906/07, p. 37-39.

51 Kolonial-Abteilung des Auswärtigen Amts (ed.), Medizinal-Berichte, 1906/07, pp. 37-39; Reichs-Kolonialamt (ed.), Medizinal-Berichte 1912/13, p. 11.

52 Ollwig, Bericht (see note 43), p. 424.

the other individuals subsumed as "Asians." Goans would not have to be submitted to blood tests, thus did not fall prey to the suspicion of being infected. Instead, Ollwig explained, the servants employed at Goan pubs (*Goanesenwirtschaften*) located in the "exposed districts" should be tested for malaria, arguing, "a considerable number of the Goans gets infected"[53] in these pubs. The European's Other was also the Goan's Other.

However, the Goan was not always that easily incorporated into the category of the European. At times, doctors' expressed doubts about the Goan's position in the social hierarchy shined through. For instance, Dr. Otto Dempwolff, who supervised the Dar es Salaam scheme for one year, expressed surprise over the observation that "the Indians show more understanding in the usefulness of malaria control than the Goans, since they often notify their sickness when they have fever attacks."[54] "Indolence", the disinterest in medical treatment, was a trait with which physicians classically described those they considered and wanted to mark as distinct from their own assumed status, a status they conceived of as highly civilized. Obviously, Dempwolff was irritated by the fact that Goans, enjoying European privileges, showed a behavior that made it less plausible to classify them as "European."

That Dempwolff, like many of his colleagues,[55] subsumed Goans under the broader category of "Asians" also reflects physicians' reluctance to grant them recognition as Europeans. Those Goans who were employed as assistants at the Dar es Salaam malaria program, too, were unlikely to have been accepted in the ranks of the European: While Ollwig admitted that they were much more useful than their African colleagues, he made clear that it was nevertheless "difficult to introduce them into the technique of microscopic diagnosis" and that the "German nurses" were the most valuable workers.[56]

From these observations we can derive two conclusions. First, Goans were granted European rights, but were repeatedly classified as "Asians," which hints at the importance of the concept of biologically distinct races for their classification and for the idea of the European. This assumption is underscored by the colonial administration's definition of the Goan: The officer commenting on the development of the colony's population in the annual report for 1912/13 obviously had had some trouble finding an adequate place for comments on the Goans in the section on the colony's population. In previous reports, this section was structured after a clear dichotomy, commenting first on the "White population," then on "Coloureds."[57] Where should the Goans be placed? The officer in charge included them in the paragraph on Whites, however he significantly placed them only at its very end. In this way, the Goans provided the bridge to the Coloureds. Obviously, the officer had not felt comfortable with fully including them into the White, but had not dared count them as part of to the Coloureds, given their official legal status as Non-Natives / Europeans.

53 Ibid., p. 445.
54 Reichs-Kolonialamt (ed.), Medizinal-Berichte 1907/08, p. 49.
55 See also Ollwig, Bericht (see note 43), p. 414.
56 Ibid., p. 443.
57 Reichs-Kolonialamt (ed.), Schutzgebiete 1912/1913, pp. 7-8.

Here, the relationship between the terms “White” and “European” becomes apparent: The section that in other reports, for instance in medical reports, is headed “Europeans,” is headed “Whites” in the annual report, implying a synonymous relation between the two terms. European thus was not only understood as a judicial category, but was imagined as being marked by bodily characteristics, too. Here, the concept of biologically defined race, was at work. The European was – or at least ideally should have been – White.

However, the case of the Goans reveals that “White” and “European” were hardly true synonyms, indeed but rather terms of different quality. For not all of those who were officially classified as Europeans and granted the same rights were without contest recognized as Whites. Whiteness indeed seems to have operated as an instrument with which positions within the European could be negotiated, enabling the assignment of an ambiguous status within the European to those undesired or less desired, such as the Goans.

Another way to place the Goans at the margins of the European was to present them as being, in the first place, of Indian descent. The comments on the Goans in the annual report make clear that administrators were concerned with distinguishing them from “*pure* Portuguese”:

> *Some Goans, whose fathers were pure Portuguese, presented themselves as Portuguese, therefore the statistics on Europeans still erroneously list some Portuguese, who from now on are accounted for separately as Goans. Pure Portuguese are not at all present in the colony.*[58]

True they received recognition as Europeans, but only with the special status “Goans” which set them visibly apart from members of European nations. This was done on the grounds of reasoning similar to what has been termed the “one drop rule,” which refers to racist classifications in the United States around 1900. It was clearly the concept of race, more precisely, of race in its biological meaning, that put Goans at the margins of both the European and the White. For the European, this meant that he was imagined as a race that could be distinguished from others on the grounds of biology.

The second conclusion that can be derived from the Goans’ case is that, nevertheless, biological race was not the only criterion available to classify people – neither for administrators nor for physicians. The annual reports, relating to “Coloureds”, repeatedly commented that “mixing” made it difficult to clearly differentiate between “Swahili,” considered to be indigenous to the territory, and “Arabs”:

> *Often religion and higher standard of living* [Lebenshaltung] *resolves the matter. Obviously, the well off, fair skinned man from the coast loves to present himself as an Arab, even if he has only little Arab blood.*[59]

58 Ibid., p. 8.

59 Ibid, p. 12; see also: Reichs-Kolonialamt (ed.), Schutzgebiete 1911/12, p. 5.

Here, it was acknowledged that "standard of living" or "lifestyle" (*Lebenshaltung*) could provide a criterion for classification of individuals. In the case of the Goans, too, *Lebenshaltung* seems to have been a relevant marker: Goans not observing the medical advices issued were shifted at least towards the margins of the ruling elite. *Lebenshaltung* might also have allowed the employment of individual "Goans" as medical assistants, an occupation that clearly set them apart from their (uncontestedly) European employers, while bringing them closer to their African colleagues. In these cases, the lifestyle of the Goans concerned might not have been "high" enough to include them into the ruling elite and to grant them a more respectable occupation. Indeed, not only (biologically defined) race, but class, too, was the obstacle for the inclusion into the European. The following example will illustrate that this could be the case even when membership in terms of biological race was not contested.

2.2 "Boers"

The category "Boers," like that of "Goans," held an uncomfortable relationship towards the category "European." Around 1905, around 200 Afrikaner refugees, fleeing the conflicts with the British in South Africa, applied for land in German East Africa and were granted some ground in the northern Kilimanjaro and Mount Meru regions. These "Boers," most of them poor, settled down as farmers, later some of them also engaged in the transport business. Soon, however, conflicts arose with the colonial administration. The authorities complained about the "Boers'" hunting activities, which they thought infracted the regulations for the conservation of game; the administration also feared that the Boers might set up autonomous political structures. The administration therefore repeatedly rejected new demands for land by the Boers and tried to allocate spare land to German settlers instead.[60]

In terms of legal status and political rights, Boers clearly counted as Europeans. In colonial reports however – and this applies to medical reports, too – Boers attracted considerable attention under the heading "European population". They were thus singled out as a special group, and the reports' wording reveals that the – German – physicians compiling the reports set themselves apart from them. Dr. Penschke, for instance, the physician stationed in the northern town of Moschi, complained that the Boers' "peculiarities" (*Eigenheiten*) prevented effective action against malaria in the districts in which they settled. Such peculiarities, according to him, included letting the surroundings of their houses become marshy, acting "completely disinterested" in medical advice and countering the theory of malaria transmission by mosquitoes, with "only an incredulous smile":

60 R. Tetzlaff, Koloniale Entwicklung und Ausbeutung. Wirtschafts- und Sozialgeschichte Deutsch-Ostafrikas 1885–1914, Berlin 1970, p. 110; Iliffe, Tanganyika (see note 49), pp. 59-61.

> *Only few can be convinced about the dangerousness of mosquitoes. "The fever comes with one wind and leaves with another!" This is their conviction and they don't let themselves deter from it.*[61]

Warwick Anderson has shown that medical scientists in the colonies constructed differences between the races by differing between reactions to disease not only by pointing at assumed given features. Not only did doctors point at qualitied assumed fixed, such as inherited immunity, but also argued that differences were due to specific behavior pertaining to hygiene. Filipinos, for instance, were said to contract cholera more easily than Europeans because they lacked the appropriate behavior to counter the threat of disease. Still, although the criteria "behavior" suggests a more flexible approach to differences, it was inextricably linked to "race." Filipinos were marked as behaving non-hygienically – and unhygienic behavior became the marker for Filipinos.[62] That Boers were pictured as not observing the rules of hygiene hints at their contested position within colonial hierarchies. Their "lifestyle" was pictured in the same way as the lifestyle of many of those termed "Native": as rural, pre-industrial and lacking rational and scientific knowledge.

At the turn of the twentieth century, a number of surveys were conducted in order to investigate the hotly debated question of whether Europeans in the tropics had achieved and could achieve some degree of "acclimatization," that is, whether they could get used to climatic and other conditions understood as being specific to the "tropics." Questionnaires used in German East Africa for that aim attempted to register whether the lifestyle (*Lebenshaltung*) of settlers in the colony was "reaching towards European lifestyle," towards "lower European lifestyle" or towards "Native lifestyle."[63] The results indicated that 49 individuals were observing higher European lifestyle, none a Native one, but that most settlers tended towards lower European lifestyle. Commenting on this last category, the physician made sure to detail that "among them [were] 69 individuals of Boer descent".[64] Thus, even if Boers were not categorically bared from membership in the European, their position within this category was problematic. What made it problematic was not – as in the Goaneses' case – their biological race, but their way of life, their culture.

The Boers' unclear position is also reflected by the fact that doctors involved in malaria control, instead of granting them the position of victims of disease that they granted to Europeans, endowed them with features attributed to the Coloureds: Penschke, in his report on health in the region of Moshi, made clear that the Boers had to be made responsible for the occurrence of malaria in the district. He argued, "the Boers in the shortest of times succeeded in systematically infesting the hitherto completely healthy regions. On their treks towards Buiko [in the northern Usambara Mountains] they brought malaria and anopheles with them and lodged them in [nisteten ein] thoroughly."[65] Previous re-

61 Reichs-Kolonialamt (ed.), Medizinal-Berichte 1909/10, p. 33.
62 Anderson, Immunities (see note 9).
63 Reichs-Kolonialamt (ed.), Medizinal-Berichte 1910/11, p. 110.
64 Ibid.
65 Reichs-Kolonialamt (ed.), Medizinal-Berichte 1909/10, p. 32.

ports, too, had accounted for the increase of malaria infections in the northern districts by pointing at the importance of "travellers passing through," among them 102 Boers affected with malaria.[66]

Clearly, Boers were conceived as sources of infection, not as their victims – in analogy to "Coloureds" and in contrast to those who in medical reports were labeled "Europeans." However, Boers did differ from Coloureds in one aspect: while the latter were as a matter of principle pictured as threats to the health of Europeans, Boers were usually blamed for diseasing themselves.[67] They provided, as one report argued, a good example for the fact that "lack of knowledge on the transmission of malaria through mosquitoes can lead to self-made harm."[68] Boers were not infecting Europeans, but only themselves – this was the reasoning that set them apart from Coloureds. Also, the importance of the concept of biological race seems to have prevented the Boers from being categorically excluded from the European. However, it is obvious that physicians only granted them a position at the margins of Europeanness.

3. Conclusion

What does this tell us about German colonial physicians' ideas of the European, about the lines and criteria for its construction? As has been shown, doctors in German East Africa as a matter of principle defined the European in opposition to his Coloured Other. They did so on the one hand in medical theory, by attempting to endow the European with specific biological traits such as disposition to or immunity against diseases. On the other hand, they did it in their day-to-day practice, by granting privileges in medical care to the European while providing modest service for his Other, and, in malaria control, by treating the European as a victim of disease that had to be protected by deploying control measures targeting his Coloured Other that was conceived as the source of disease.

The categories "Goans" and "Boers" have illustrated that, even from the perspectives of medical doctors, who was granted membership as European was far from self-evident, but had to be constantly negotiated. Additionally, they reveal on what grounds physicians negotiated membership in the "European": they described Boers as having unhygienic habits, a pre-industrial way of life and as being poorly educated. The descriptions reveal that doctors conceived of themselves as the Boers' opposite – as individuals respecting the rules of hygiene, being modern and being highly educated. What, from the physicians' point of view, set both of them apart from Boers was lifestyle, culture

66 Kolonial-Abteilung des Auswärtigen Amts (ed.), Medizinal-Berichte 1905/06, p. 35.

67 This idea has been termed „Selbstschuld-Paradigma" in the research on medicalisation and the working classes in imperial Germany. See: U. Frevert, Krankheit als politisches Problem 1770–1880. Soziale Unterschichten in Preußen zwischen medizinischer Polizei und staatlicher Sozialversicherung, Göttingen 1984, p. 136; J. Reulecke, A. Castell Rüdenhausen, Von der ‚Hygienisierung' der Unterschichten zur kommunalen Gesundheitspolitik, in: J. Reulecke, A. Castell Rüdenhausen (eds), Stadt und Gesundheit. Zum Wandel von ‚Volksgesundheit' und kommunaler Gesundheitspolitik im 19. und frühen 20. Jahrhundert, Stuttgart 1991, pp. 12-14.

68 Reichs-Kolonialamt (ed.), Medizinal-Berichte 1908/09, p. 14.

and class. Indeed, we find other evidence for class having been considered as a relevant marker for difference in German East Africa: For instance, Europeans had to provide proof of sufficient financial means if they wanted to settle in German East Africa. The colonial government explicitly discouraged immigration of "destitute Europeans,"[69] and influential colonial lobbyists advocated the settlement of members of the higher educated European classes in order to build a settler aristocracy in the colony.[70] Interestingly, too, when the governmental hospital was set up in Tanga, the European section was provided with "3 big rooms for the division of patients of different ranks" (*3 größere Krankenräume zur Abtheilung der Patienten unterschiedlicher Stände*).[71] We can presume that "the Boers" whom Penschke described in Moshi would not have been bedded in the rooms reserved for the highest ranks. At the same time, the case of the urban, Christian, *petit entrepreneur* and Western-styled Goans shows that culture and class did not always suffice to successfully claim membership to the "European." From both the administrators' and the physicians' perspectives, the concept of biological race, expressed through ideas of whiteness and blood bonds, was used to keep Goans at arms length from the European and to create the Goans as "not quite European."

Thus, colonial physicians used a combination of biology, class and culture in order to draw boundaries around the European. Was the European then a race, class or culture? To pose the question this way would be to fall prey to the illusion that the concept of race can be isolated from class and culture and to fall prey to the idea that in contrast to the latter obviously social categories, race holds some kind of primordially given, natural quality. It has repeatedly been shown that the concept of race neither initially denoted a biological category, nor always referred to color. Instead, it developed from the eighteenth century on as a term with which conservative observers commented on social change in Europe. As such, the notion of race was, as Kenan Malik explains, "most imprecise": "The idea of 'peoples', 'nations', 'classes' and 'races' all merged together."[72] Race served to point out differences within European society, to assign a place to "'the primitive' areas and groups within the home country,"[73] most notably to the working class. Its transfer to the Colonized and its, however still not exclusive, association with color developed only in the late ninteenth century argues Malik, for the British context. Etienne Balibar puts the emphasis not so much on the historical sequence of the different meanings of "race," but instead on the continuity of its multiple layers, that is its economic and social aspects. He points out that the focus on bodily markers is far from being characteristic only of what he terms "ethnic racism," but is at the core of anti-working class discourse, of "class racism", too. For him, both forms of racism build on attempts to "somatise,"

69 Governor Götzen, cited in: R. Tetzlaff, Koloniale Entwicklung (see note 60), p. 105.

70 B. Kundrus, Moderne Imperialisten. Das Kaiserreich im Spiegel seiner Kolonien, Köln 2003, pp. 112-113; R. Tetzlaff, Koloniale Entwicklung (see note 60), pp. 103-106; B. Zurstrassen, ‚Ein Stück deutscher Erde schaffen'. Koloniale Beamte in Togo 1884–1914, Frankfurt a. M. 2008, p. 53.

71 Plehn to Wissmann, Tanga, 18.11.1895, in: TNA G5/4, p. 11.

72 K. Malik, The Meaning of Race. History and Culture in Western Society, London 1996, p. 80.

73 D. Pick, cited in: Malik, The Meaning of Race (see note 72), p. 81.

that is to reduce both the worker and the immigrant or Colonized to bodies in order to make them available as work force. According to him, race and class have from the start been intertwined, and continue to be.[74]

Thus race, far from being clearly demarcated, is a "multi-faceted concept."[75] Therefore, I propose not to assume that, when physicians conceived of the European as a race, they defined him as a biologically distinct phenomenon only. Instead, it would be more appropriate to conclude that physicians conceived of the European as a race that they set apart from others on the grounds of biology, class and culture.

The invention of the European in German East Africa was not the privilege of colonial physicians. The category was omnipresent. It figured in administrative reports, in anthropological descriptions, in colonial novels and much more. In its invention by the colonial administration, it operated as a political category: the European was the one who was granted specific political rights. He was able to apply for land for settlement and he could vote for and become a member of a number of political institutions. It is the enactment of these privileges that transformed the category of "European" into a group in whose name individuals were able to claim rights and advance requests. The European, thus, was not a medical invention. However, physicians contributed in reifying this category through their medical theories on biological differences and through their practice of differential treatment, based on ideas of culture and perceptions of class differences. Just as the administration had to constantly reinforce the category of "European" by creating a legal dualism, by barring Africans from participation in political institutions, by designing regulations on architecture and city planning (*Bauordnungen*) that contributed to segregating cities, and by restricting agricultural activities of the colonized, the medical doctors reproduced the European in the same way by insisting on segregating hospitals, treatment and statistics. The cases of the Boers and Goans highlight the fictive character and the fragility of this boundary making.

These cases also illustrate that the definition of the European was negotiated on the basis of who was desired as a member of the ruling elite and who was not. Thus, the European was a political category. Colonial doctors did nothing more than to reproduce and enact this category through their practice and to attempt to back it with biological meaning – just as anthropologists backed it with culture. All these endeavors – political, anthropological and medical – were attempts to differentiate people into citizens and subjects on the basis of racist ideologies that were built on class, ideas of culture and ideas of bodies. The European, in conclusion, was first and foremost, for administrations as well as for medical experts, a category of colonial rule.

74 Balibar, Class, Race (see note 44), pp. 211-212.

75 Malik, The Meaning of Race (see note 72), p. 71.