Insights from an
African History of Disability

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In 1996, I traveled to Botswana seeking the histories of men disabled by accidents in the South African mines. I knew the mines were notoriously dangerous places, and that historically the mining industry had treated African workers as disposable, drawing in the able-bodied and farming the damaged back out to the rural communities from which they had come. I also knew that the mines had dominated male employment opportunities in Botswana (formerly Bechuanaland) for much of the twentieth century. When I arrived, sure enough, these men were there. Many were easy to spot, sitting in corroding wheelchairs issued by the mining companies in front of their compounds, or drinking beer with friends in the shade. I soon found, however, that these men were only the most visible segment of a much larger disabled population that encompassed women, children, and the elderly, as well as adult men. Yet as I was shocked to learn, the former miners were considered the fortunate ones. Many—though by no means all—of them had received wheelchairs, leg braces, prosthetic limbs, and perhaps even a paltry sum in “compensation” for the battering of their bodies from the ever-magnanimous mines. Nonminers with physical impairments might receive a wheelchair or other technical aids from the patchwork of NGOs and government programs that provide services to disabled persons in Botswana—or they might not. The mines themselves had the most clear-cut system for processing newly impaired persons and providing them with tools for managing their new bodily states. Perhaps this should not have surprised
me: they had an equally efficient system for severing limbs and swelling brains and crushing spines.

For much of the twentieth century, a political economy based on overlapping British colonial and South African industrial interests unleashed a certain physical violence on the people of southeastern Bechuanaland. Taxation, land alienation, and the resulting labor migration generated a downward spiral of poverty, and poverty bred disease and impairment. After national independence in 1966, fortunes changed suddenly, as newfound diamond wealth fed the development of infrastructure, schools, and new health and welfare services. While poverty continued to breed disease and impairment among many Batswana, others were trapped midway in an epidemiological transition brought by the new money. Improved nutrition and the spread of biomedical services since the 1970s enabled increasingly larger numbers of people to survive disabling illness or trauma and many more to experience the frailties of old age. Chronic illnesses existed side by side with debilitating impairments generated through partial biomedical solutions. For example, meningitis could now be treated, but children who survived its ravages often faced truncated and pain-filled lives. New roads and vehicles increased mobility, but they also meant that new accidents claimed limbs, brains, and spines daily. In recent decades, an epidemic of HIV/AIDS has swept the country, furthering anxieties over the vagaries of embodied life. By the mid- to late 1990s, an estimated one in six or seven rural households in southeastern Botswana was home to a disabled family member.

The idea that an African man whose spine had been crushed while working in a highly capitalized, white-owned industry, for minimal wages, in an institutionally racist state could be considered lucky challenged my understandings of political economy, and it served as my first indication that I would have to rethink my project on disability. That the parents or siblings of such a man could potentially hold the man’s wife (still resident back in Botswana) or a jealous coworker accountable for the collapse of a rock ceiling nearly a mile underground in a South African mine further shook my sense of what was at stake here. When other people I met with disabilities and their relatives spoke positively about neighbors, friends, and community workers who felt “pity” or “sympathy” for them, my American sensibilities were further undermined. Difficulties in translating common English terms into Setswana and vice versa posed additional problems. Determining the changing and contested meanings of disability and able-bodiedness through very fragmentary archival and oral historical evidence became puzzles that dominated my attention. But solving those puzzles also led me to confront much more complex epistemological challenges as I struggled to understand what at first seemed like a radically different form of corporeality from my modern Western sensibility, however historically informed.

This series of puzzles and attendant epiphanies led me to expand the scope of my project: first to a history of disability more generally, and eventually to a study
of debility, a term I gloss as the impairment, lack, or loss of certain bodily abilities. Debility, as I will describe, encompasses experiences of chronic illness and senescence, as well as disability per se. This reorientation of my project led me into the rich intellectual resources coming out of the burgeoning field of disability studies. But as this field has thus far been predominately grounded in Euro-American issues and experiences, I found myself at times navigating my way across some uncomfortable conceptual space as I sought to align the questions emerging out of my research with those of other scholars writing about disability. It is this process of navigation that is the focus of this essay.

Below I reflect on some of the challenges I faced in writing a history of debility in southeastern Botswana. These challenges stemmed from two primary issues that emerged in my attempts to bring a disability studies perspective to a historical project originally conceived in African studies terms. First, the marginalization of the somatic aspects of impairment in the field of disability studies contrasted with their emphasis in Botswana. Second, the dominance of Euro-American concepts of individuality and independence that underpin rights-based language on the one hand, and physiological understandings on the other, again contrast sharply with Tswana notions stressing the social permeability of the body and the person. Though disability studies scholars emphasize the social construction of disability, for the most part they still employ (often implicitly) a notion of individual selfhood, complete with an individually bounded body that is itself a social construct. This makes for an awkward translation between the English term disability and its Setswana counterpart, bogole.

I do not claim to have written a definitive history of disability in Africa. Africa is much too large and diverse a place, and disability much too complex a topic, to write about in any definitive way. Nor are these reflections meant to set the history of disability in Botswana or in the broader African region apart from better-documented Euro-American histories of disabilities. For one thing, the commonalities across geographical and cultural contexts are highly significant. In Botswana, just as in the West, people have used the presence of disabled bodies to perform paternalism and public charity in an attempt to reinforce a sense of moral community—even as these very acts highlight difference, construct disability as victimhood, and thereby undercut attempts to promote inclusivity and self-determination. In southern Africa, as in Europe and North America, the introduction of transnational capital and new industrial forms of work over the course of the twentieth century have introduced new meanings and experiences of disability, just as hazy notions of “able-bodiedness” have been key determinants of access to economic and, therefore, social opportunities. Meanwhile, the introduction of certain social and medical services and the uses of particular forms of identity-based language by disabled Batswana have facilitated the emergence of a collective identity around disability. In recent decades, a burgeoning disability rights movement—in
which activists struggle for equal access to economic, political, and social opportunities—has taken root and flourished in many parts of Africa. The history of disability activism in Africa has yet to be written, and I hasten to add that this history remained mostly outside the scope of my own research. But despite these and many other historical parallels, the epistemological challenges I have delineated above are nonetheless instructive, and it is to these issues that I now turn.

My aim here is twofold. I want to explain something about Tswana ideas and experiences of impairment and bodily permeability. This type of exercise is necessary if we are to expand our knowledge of disability history outside of the West to the geographic contexts in which so many people with disabilities live. But I also want to suggest that the ideas and experiences in Botswana I describe are not as foreign as they seem at first glance. By stepping outside Euro-American contexts in pursuit of a different political economy and culture, I think I have also gained insights that might be relevant and useful within North America and Europe. I begin with an explanation of the term bogole, the closest Setswana counterpart to the English term disability. I then turn to a discussion of the importance of impairment, and conclude by reflecting on Tswana challenges to Euro-American notions of independence and bodily individuation.

**Bogole/Disability**

*Bogole* was surprisingly hard to define at first, though over time its meanings became clearer to me. It certainly overlaps with the English term *disability*, and over time, its meanings have been increasingly shaped by the agendas of those who translate freely between the two terms in rhetoric and practice, assuming a natural alignment between them. But they are not direct equivalents of one another. *Bogole* operates in two overlapping registers. First, there is the meaning of the identity as it unfolds in the experience of an individual. Second, there is a more general abstract understanding of the term that relates to the question of normalcy. Over the course of my research, I observed diachronic aspects of *bogole* unfold for persons I knew, and I also collected historical narratives about individuals that reaffirmed this aspect of disabled identity. *Bogole* signals an end phase in the search for cure and healing. In Botswana such searches can be quite lengthy and arduous, propelling subjects and their relatives from healer to healer, often across different therapeutic systems such as *bongaka* (Tswana medicine), Christian healing, and biomedicine. In the process of searching for a cure, precious resources are exhausted, and controversy is often engendered among both healers and patients. Such controversies can strain families past the breaking point. Members struggle to define the causes of impairment as a necessary precursor to cure, but debating the attendant meanings of those causes often precipitates struggles over morality. Sometimes, despite the lack of cure, which is sought as the primary goal, the *molwetsi* (patient) and his or her relatives find palliation, easing the transition to a new bodily state now figured as *bogole*. For some
the “quest for therapy” is only metaphoric. Those who lack the social or economic resources to actively pursue cure may instead yearn for the reputed skills of earlier generations of healers. Still a time will come when even this metaphoric quest draws to a close and the identity of molwetsi gives way to that of segole (disabled person).

Through these processes of quest and negotiation, the disabled subject and those closest to him or her develop explanatory narratives. These narratives are deeply social and moral tales. Faye Ginsburg and Rayna Rapp explain that disability entails a “rewriting of kinship.” In Botswana, where persons are constituted bodily through their social relationships, kinship idioms and bodily idioms overlap, and where historical changes have made kinship an important site of negotiation and struggle, these kinship revisions are particularly evident. Through narrative explanation, the character of bogole articulates with the story of a person to frame which aspects of the new identity are imbued in the disabled person and which wash over onto family members, neighbors, friends, and caregivers.

Normalcy, the second dimension of the concept of bogole, was harder to grasp in clear-cut terms, as concepts of normalcy are not as fixed as “normates” might imagine. For example, Rra Sethata, a paraplegic man labeled segole by his relatives, coworkers, and neighbors, deflected the question of bodily normality onto social normality when he told me, “I am not disabled, I am rich in friends.” A woman I knew who gave birth to five children born with microcephalitis, explained that in earlier decades such differences would not necessarily have constituted bogole. Certainly people would have noticed her children’s heads, and some might have ridiculed them because of this. But in the late 1990s, this difference in appearance was linked to key abilities, and so it had now become a clear marker of status. Over the past two decades, as Western education had become a necessary pathway to self-making and success, her sons, who otherwise would have been (or would have seemed destined to be) able-bodied farmers and cattle herders, were now considered digole (disabled persons). But despite and amid these destabilized understandings of “normal,” Batswana remarked time and again that “segole: well, that is someone who is not normal” when I asked them to define the term. In these two themes, we have both the explicit definition of disability and the implicit (and, at times contested) way in which it unfolds for the subject. These themes are woven together in the wider history of southeastern Botswana.

Disability studies scholarship often stresses the centrality of modern Western notions of normalcy in structuring historical experiences and representations of disability. But normalcy in relation to bogole operates somewhat differently for Batswana than normalcy in relation to disability does for Euro-Americans. I suspect all societies invoke norms to understand bodily difference. But in places like Botswana, where health and physicality are located and defined within social (particularly kin-based) relationships, notions of normal bodies and normal relationships are two sides of the same coin. In Botswana, the disabled individual is the embod-
ied nexus of a set of social relations, the character and shape of which are open to debate. Indeed, that *segole* is defined as “someone who is not normal” in Botswana reflects the relational and ongoing character of embodiment more than it does a sense of idealized body types or capacities. Disability studies scholars understand relationships to shape impairment or difference into disability through social exclusion and stigma, and through invocation of a medical model that classifies certain bodies as broken and deficient. By contrast, Batswana, by invoking their own medical model of bodily permeability that interprets certain relationships as broken or toxic, understand impaired relationships to generate bodily misfortune, which in turn is managed as *bogole*. So both disability and *bogole* are about bodies and social relationships, but in somewhat different ways. Stigma then aggregates in different ways as well. While there are similarities between disability and *bogole*, there are also very important disjunctures.

Despite these fundamental differences between *bogole* and disability, the meanings of *bogole*—never a static category—over the past century have been shifting in part through the history of colonialism, industrialization, globalization, missionary activity, and other complex interactions between Botswana and Euro-America. For example, throughout the twentieth century, precolonial social and political hierarchies based on class, gender, ethnicity, and age increasingly came to operate in tension with new categories that had begun during the period of British social engineering. The so-called civilizing mission—the arm of the colonial project inspired by contemporary Christian and bourgeois values—broke up personal attributes for ranking in relation to a norm. Beginning in the 1930s, the standardization of bodies and minds became a hallmark of British colonial culture in Bechuanaland, and anthropometry—the ranking of bodies by physical “types” according to scientific standards of measurement—gradually crept into public understandings of bodies and their capacities. This project picked up pace in the 1940s, and by the mid-1990s, every child I met held a clinic card with his or her height and weight measurements diligently plotted against a “normal” (i.e., metropolitan) growth curve. Since the 1970s, Apgar scores recorded at birth help identify infants at risk for “delayed milestones.”

Likewise, over time, Tswana notions of able-bodiedness were reshaped by European industrial evaluations of fitness. From the 1930s onward, men who sought work in the South African mines—a virtually ubiquitous experience among African men in southeastern Bechuanaland, due in part to colonial policies—faced a medical examination to determine their “fitness” for work. Those whose bodies were deemed “unfit” for industrial employment by virtue of their age, weight, perceived impairments, or other criteria were economically and thereby to some extent socially marginalized. Bodily differences that had previously seemed economically inconsequential began to take on greater social and economic valence and to remake particular hierarchies. This forging of the standardized normal, begun through British colo-
nialism and accelerated in the postcolonial world of international health, Western-modeled education, and neoliberalism, has in turn patterned the boundaries of one aspect of the normal, outside of which lie the meanings of *bogole*, as represented in the experiences of microcephalic school leavers.

**The Importance of Impairment**

In her seminal work on disability, Simi Linton drew attention to the need for serious theorizing about impairment itself. For the most part, however, this work has yet to be done. Below I do not so much theorize as draw attention to the centrality of impairment in Tswana history and raise questions that emerge from a focus on it. My emphasis here on impairment is not meant to deny that disability is indeed socially constructed—it is—but rather to suggest that the story does not end there. Impairment, or the material basis of bodily experience, matters as much to Batswana now as it did to Batswana in the historical past. Over the course of the twentieth century, large-scale political, economic, social, and biological transformations in Botswana generated new forms of impairment and disability, and these two facets need to be disentangled for one to understand the complexities of this history.

Taking impairment as a point of analysis highlights one of the paradoxes of modern studies of disability: the uneasy and uneven relationship between medicine and physical identity and experience. On the one hand, Westerners enjoy many medical technologies and practices that ease bodily suffering and facilitate self-determination. On the other hand, we rightly resent the reductionist power of medical practitioners, the triumphant narratives of biotechnological progress, and the saturation of public discourse with biomedical language that powerfully determines and defines our public standing. Somewhere beneath this paradox lie the material dimensions of the body that defy deconstruction. The political economy of health care and technological proliferation and access in Botswana (as in much of Africa in general) resituates such tensions, given that biotechnological access has been sharply limited and that the maintenance of technologies remains a serious problem. This is especially true given the history of biomedical expansion there. Biomedicine in Botswana has long coexisted with other dominant forms of medical understanding; it is far from hegemonic. These other therapeutic systems have produced knowledge that reveals our notions of individually bounded bodies to be yet another folk tradition, while also producing different idioms and networks through which stigma and power operate. In this context, representations and experiences that arise from rehabilitative technologies and practices are at least partially separable.

In Botswana, as in all places, the pathways in and out of impairment are political, economic, and cultural, just as are the pathways in and out of disability. In a context where the predations of colonialism and capitalism have contributed to rising rates of physical impairment, it is hard to think about the suffering induced through the casting of impairments as disability, as well as the attendant stigma and
foreclosure of opportunity that this construction can present, without also considering the potential suffering induced through the generation of such impairments in the first place and the material challenges they can present. Similarly, even the most superficial comparisons of technological and medical access across various national or cultural contexts suggests that many of the impairments that are defined as disability in Botswana would have been prevented or stabilized in a more highly capitalized country. Despite the political problems that I readily acknowledge with rehabilitation as a set of discursive and, at times, violent physical practices, there are material benefits to some rehabilitative goods and services. Wheelchairs, cushions, canes, and eyeglasses, much like the antiretroviral drugs that are so badly needed in many African countries, not only help relieve physical pain and discomfort and prolong life but they also help debilitated persons to access economic and political rights and opportunities. Separating disability from impairment perhaps also helps us separate the cultural power of rehabilitation to shape public sentiment from its potential to empower individuals to realize opportunities for themselves.

Rehabilitation and the proliferation of bodily technologies in Botswana have not operated historically within a cultural model of technological determinism. This is important. Their cultural power to determine meaning and experience has been sharply curtailed by the uncertainties of undercapitalized biomedicine as it has played out in Bechuanaland/Botswana. Despite the fact that some Batswana have begun to invoke mechanistic imagery when describing the human body, they by no means liken impaired bodies to broken machines, nor do they envision a world in which technological fixes will obviate the need for grappling with difference through benign sentiment and healthy social relationships. In this context we might look closely at impairment without succumbing to some of the perils of reductionist reasoning.

Rehabilitative projects run a range, and impaired actors put bodily technologies to a range of uses that are at least partially determined by the political and economic contexts in which they are deployed. As a teenager, I was fitted with a back brace that was intended to make my curved spine behave in an upright and straight fashion. In the 1970s, all across the United States, girls like me were asked to bend over and touch their toes in gym class so that we could be diagnosed for scoliosis. “Abnormal” curves led to wearing braces or undergoing “normalizing” surgery. My back brace was painful to wear, but I was meant to wear it constantly. Fortunately my mother quickly agreed that this enterprise was barbaric, and we abandoned the brace in the trunk of a taxi after only a week’s time.

I think, however, that my experience differed somewhat from that of Nomsa, a woman I met in Botswana who wore a prosthetic leg. She had problems with the prosthesis: it did not fit well, making it painful to use, and she rarely wore it when at home or in the immediate neighborhood. While she received her prosthesis as part of a growing global rehabilitative enterprise, rehabilitative reasoning was far from
hegemonic in Botswana. I do not imagine that many people in Nomsa’s life figured her as a broken machine in need of a spare part. Nomsa did not wear her prosthesis for aesthetic reasons. Nomsa wore this ill-fitting prosthesis to farm her fields. For decades after she had her leg amputated at the thigh, but before she received this artificial limb, she had hoed her fields by crushing a metal drum to the height of her thigh and balancing her shorter leg on top. As she moved across her field, she dragged the drum with her. It was not that she could not farm without her prosthesis—and, indeed, in the 1950s some Tswana women whose spines had collapsed from tubercular infection farmed their fields on hands and knees, with discarded pieces of motor tires strapped to their knees—but, just like her hoe, Nomsa’s prosthesis made the job easier and less grueling.

A focus on impairment also reveals key areas of common interest and overlapping history between people with disabilities and those whose bodies are debilitating or otherwise impaired by virtue of illness or aging. Putting disability and other impairments into the same frame of analysis reminds us that there are many people who are passing as normates, a social fact with deep political and cultural implications. But this fact also opens important questions about the cultural and intellectual relationship between divisive categories like disease and disability in any given society, and the role of gender and age in parsing them. Social and cultural location helps determine who is passing, how that is accomplished, and where the limits of such efforts lie. Women who have undergone a mastectomy in the United States, for example, might not identify themselves as disabled. In Botswana, mastectomy is rare, as is cancer treatment of any kind (though I hasten to add that cancer itself is certainly not uncommon). But hysterectomies are performed, though in nowhere near as great numbers as in Europe and North America. One woman I knew was divorced by her husband after her hysterectomy, on the grounds that he “didn’t want to be married to another man.” Here the comparison with Botswana raises important questions about the differences between outwardly obvious and seemingly hidden impairments and their relationship to disease, disability, and gender. In Botswana, having an unusual body shape does not seem to challenge general expectations of sexual attractiveness in the same way it does in the United States or Europe, and it does not seem to be a major motivating factor in the use of prosthetics. Yet the sexuality of those women with normative outward appearances but non-normative internal anatomies was deeply in question.

Similar lessons can be drawn by contrasting experiences of aging across contexts. The experience of hip fracture that so often signals the end of independent living for many elderly Americans today reveals significant cultural, social, and economic issues rooted in a twentieth-century history of urbanization, shrinking and fragmenting families, and late capitalist labor patterns. Even if these impairments are to a great extent normative and even expected for elderly Americans, and they are not constructed in certain circles as disabilities per se, they raise central ques-
tions about the relationships between opportunities, social capital, and particular forms of embodiment that are highly salient for studies of disability, as well as for the politics of disability activism.

In Botswana, reduced mobility and physical strength, as well as blindness and a range of other infirmities, have long marked understandings of senescence. These were not regarded as disabilities: indeed, they were “normal” and in some cases even expected impairments. Historically, they also were recognized to accompany increased spiritual insight and other abilities. In more recent times, however, the imperative of wage earning and its attendant migrancy, the rise of Western educational models, and other social and economic transformations have marginalized the elderly and shifted household dynamics of productivity, decision making, and resource allocation. In this new context, the impairments of aging are more likely to be seen as misfortune and appear troubling to the elderly who struggle to maintain adequate networks of care. They are not disabilities per se; but this does not mean that impairment is only problematic by virtue of its potential casting as disability. Moreover, as I have described elsewhere, rising rates of debilitating stroke are occurring amid reconfigurations in the life cycle, in which senescence and social aging are increasingly out of synch with one another, and within a constrained domestic economy of care. This situation has engendered negotiations over the meaning of impairments. Family members now debate whether a grandmother’s hemiplegia should be understood within a framework of bogole or that of old age. These are significant debates given that differing understandings underscore different networks of caregiving, obligation, and dependency.24

Social Embodiment and Webs of Dependency

In order to understand more fully the differences (and underlying similarities) between bogole and disability, we have to look more closely at Tswana embodiment. The social permeability of the human body in Tswana physiology and the webs of interdependency that mark social life are deeply intertwined in daily life, in medical thought and practice, and in instances of impairment and disability. The mixing of blood and semen through sexual contact, pregnancy, and breast-feeding links people to one another bodily. Relatives share blood with one another (indeed the term for relatives, losika, is related to the term for veins and nerves, ditshika), and this underscores their social obligations toward one another, as well as their vulnerability to the actions of others. Relatives also share feeling, originating in the heart, especially given that nerves and veins operate as a single system in Tswana physiology. This means that the bitter, angry, or jealous feelings in one person have the potential to harm another, even if those feelings were involuntary, while love, sympathy, and other such feelings in one person can help to sustain and strengthen others. People also share an environment that is understood to be either toxic or sustaining, depending on the actions of others. That environment is a historical prod-
uct, produced through the purposeful labors of ancestors and imbued with their essence. The mowa (breath, soul, spirit) of a person continually moves from within the body to the environment and back through the act of breathing. So the bodies of individuals are deeply connected to one another in a range of ways — ways that Euro-Americans should recognize as not so dissimilar to their own forms of embodiment, though framed with different emphases and through different idioms.

This sense of embodiment has historically been informed by Tswana medicine (bongaka) in the same way that Euro-American embodiment has been informed by biomedicine. Even though popular knowledge and experience of the body draws on more formal knowledge, laypersons do not often expound on embodiment in abstract terms in the same way that experts do. Of course, this is not to suggest that there is no sense of individualism in Botswana, either historically or today. My point is not to construct a false contrast between communitarian Africans and individualistic Euro-Americans — such a project would be highly misleading. People in Botswana understand their inner thoughts and feelings to be their own, just as they recognize that each human being has a unique physical appearance. Responsibilities toward others are always negotiated in tension with personal desires. An ethos of self-making suggests the need to create and work at opportunities, to engage in projects that develop the self, financially, spiritually, socially, physically, and so on. But such projects of self-making are nonetheless recognized as social endeavors. Paying for a child’s school uniform, contributing to a sibling’s bridewealth, helping parents build a home, visiting relatives, neighbors, and friends in their homes, praying with fellow congregants, and attending funerals are all practices that enhance the self by solidifying and strengthening linkages between self and others, and between yesterday, today, and tomorrow.

Building on this foundation, Tswana approaches to disability help us to question how Western culture fetishizes independence as a universally desirable biosocial state. Americans in particular place a tremendous emphasis on independence — and, increasingly, the autonomy that derives from the politics of privatization — in conceptualizing adulthood, masculinity, and citizenship. Batswana, by contrast, while valuing autonomy, also stress the relationships — of dependencies — that sustain personhood. Not only is it hard to imagine extricating an individual body from the complex relationships that continually shape it but also both autonomy and dependency are regarded as historically important aspects of Tswana selfhood. In 1996, when Rra Wangura’s grandson pushed his wheelchair over the long and winding paths that lead from the family compound to the public meeting place in their ward of the village, Rra Wangura’s status as a person who had aggregated dutiful dependents over a long life was highlighted, as much as was his physical reliance on the assistance of others. Meanwhile, pushing Rra Wangura’s wheelchair, the grandson reinforced his grandfather’s position and worth and engendered positive sentiment in his grandfather’s heart, which in turn helped foreclose potential avenues to mis-
fortune. Americans also live in similar webs of dependencies, but, unlike Batswana, Americans shift these relationships to the background in understanding selfhood. This creates problems when discussing disability in America because dependency is taken to be a negative attribute, a sign of weakness, rather than something found in and valued by most human cultures.

The emphasis on dependent relationships does not, however, free Batswana from stigma and negative sentiment; rather, such emphasis sometimes flows through different channels and aggregates in different places. For example, instances of childhood impairment that Western biomedicine would typically identify as cerebral palsy is usually understood as mopakwane in Tswana medicine. Mopakwane arises when one of the parents of an infant engages in proscribed sexual relationships (though in practice the mother is usually the one blamed), by engaging in sexual activity with a third party during pregnancy or in the months immediately following the infant’s birth. This engenders a mixing of the blood of too many different people in the mother, which is understood to be toxic. As toxins build up in the mother’s body, she passes them along to her infant through breast-feeding. These toxins cause impairments in the infant. This child will usually be acknowledged as a segole, and he or she will, no doubt, experience some negative sentiments and attitudes by virtue of his or her impairments. The bulk of the stigma, however, will be directed toward his or her mother, since many will take the child to be living proof of her deviant sexual behavior and self-centeredness.

Mopakwane emerged as a key diagnostic category in the period after World War II. In the 1950s, many Tswana men spent long periods of their adult life away from their families while working in the South African mines. This had been a dominant employment pattern for several decades, but in the 1950s and 1960s, it merged with rising evidence of female autonomy, including sexual autonomy fostered by new employment trends for women, the events of the war, and the consolidation of the experience of male absenteeism. In this new social and sexual climate, the presence of disabled children was seen increasingly as a marker of aberrant female sexuality. In response, some (but by no means all) mothers began hiding disabled children in their compounds, well out of public view. In this historical example, we see how the bodily permeability of the child and the parents, mapped onto gendered social hierarchies, made many mothers vulnerable to potential stigmatization. This, in turn, deeply affected the life experiences of the child him- or herself, not primarily because his or her body was stigmatized as different or deficient (though some people may have felt this), but because the social relationships that his or her body evidenced were stigmatized as deficient.

I have drawn an admittedly static physiological model of disability in Botswana, mostly for heuristic purposes. Over the past century, Tswana medicine and biomedicine, as well as Christian-influenced healing strategies, have become increasingly entangled in Botswana. While disability studies scholars have drawn
attention to the deep perils of the medical model and of biomedical practice in the
West, an analysis with which I concur, there are nonetheless many situations in
Botswana where, for some, invocation of a medical model has been highly liberat-
ing. In Botswana, there are instances where people have embraced a biomedical
model since it allows them to shed the focus on polluted relationships and devi-
ant sentiments and sexualities to which Tswana medicine typically draws attention.
Instead, a biomedical model locates impairment in a single body rather than in a
social network. Since the 1980s, some mothers and grandmothers have embraced
the cerebral palsy reasoning brought by biomedically oriented rehabilitation work-
ers in deflecting accusations of *mopakwane*. Explaining their child’s condition to
be caused by oxygen deprivation during delivery has allowed some women to shift
attention from their own sexuality. Instead they blame incompetence at the hospital
or the vagaries of nature for bringing cerebral palsy to their child. In the process,
they facilitate a context where it is easier to bring their child out in public and to
seek opportunities on his or her behalf. In some instances, isolating an impaired
body as a broken machine, rather than as the embodied nexus of a set of toxic rela-
tionships, has proven beneficial for its potential to diffuse some, but by no means all,
of the stigma and exclusion that shapes impairment into disability.

I want to be very careful here. I am not advocating one model or another as
necessarily beneficial; both models (bodily permeability and bodily individuation)
have been caught up in tremendous suffering, while also generating some produc-
tive insights. Rather, as disability history and disability studies increasingly open
up to non-Western histories, opportunities arise not only for gaining new empiri-
cal knowledge but also for rethinking the very categories that underlie the socially
constructed models on which so much analysis rests. Botswana is different from the
United States or France. Yet these countries’ histories are entangled in one another
in complex ways that we have yet to even begin to unpack. It is my hope that these
reflections present one of many possible ways to begin such an endeavor.

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him and Teresa Meade for editorial support and encouragement.
1. This essay draws on work in my book, *Debility and the Moral Imagination in Botswana*
2. See Rachelle Arkles “The Social Consequences of Industrial Accidents: Disabled Mine
   Workers in Lesotho” (master’s thesis, University of Witwatersrand, 1993); and Randall
   Packard, *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and
3. I have tried to keep the non-English terminology to a minimum here, but some Setswana terms are necessary. Setswana, like all Bantu languages, classifies nouns through a system of prefixes. Setswana refers to the language and culture of the Tswana ethnicity. Motswana is a single Tswana person, Batswana are multiple Tswana persons, and Botswana is the collective noun for all Tswana people and hence the name for the modern nation. Often English speakers use the root term Tsswana as a substitute for Batswana or Setswana. Though many people who live in South Africa share this ethnicity, as well as certain historical experiences with people in Botswana, this article refers only to the history of those Batswana from the country now called Botswana.

4. Stephanie Cohen, personal communication with the author. This figure generally holds true for the village wards I have worked with through the community-based rehabilitation program. The reader should note, however, that in these one out of six households, there is often more than one disabled resident. It is easy to think of compounds where two, three, four, or even five disabled persons live. In 1999, a fellow researcher along with local clinic staff and a Motswana research assistant conducted a series of three ward house-to-house surveys to gauge the incidence of disability. Each survey covered all compounds of a single ward of a village. Two of the villages chosen were rural, and one was peri-urban. Survey respondents were not necessarily household heads, but all were resident household members. They were asked to report the number of disabled persons in the compound. The results showed a reported prevalence of 4 percent in the peri-urban village and 8–9 percent in the rural villages. See Stephanie Cohen, “Community Based Rehabilitation in Botswana: Theory and Practice in a Dynamic Context” (unpublished paper, 1999), 39. The government census found that one in ten households housed a disabled resident, but the majority of disabled persons live in rural areas, as Cohen’s figures show. Government of Botswana, Central Statistics Office, Living Conditions in Botswana: 1986–1994: Socio-economic Indicators Based on the 1985/6 HIES, 1991 Census, and 1993/4 HIES (Gaborone: Government Printer, 1996), 55.

5. This is not to suggest that all persons with disabilities in Botswana spoke in this way.

6. Important exceptions include the work of essayist Nancy Mairs and that of the late Robert Murphy, an anthropologist. Both of these authors have written in the first person, which perhaps contributes to their ability to fold the somatic and the social together so well. They each reflect on these processes of bodily transformation in existential and narrative terms, while probing the social and cultural implications of disability in American society. Both also developed their impairments as adults, impairments that increased in severity over time. Perhaps when impairment is caught up in ongoing and accelerated processes of bodily transformation, as it is/was for Mairs and Murphy, the somatic aspects of it are differentially situated vis-à-vis the subject than they are in instances where impairments are more stable in their manifestations. See Nancy Mairs, Waist High in the World: A Life among the Nondisabled (Boston: Beacon, 1996); and Robert Murphy, The Body Silent (New York: Henry Holt, 1987).


8. I appreciate the immensely productive insights that have come from scholarship that seeks to move past the artificial dichotomy of impairment versus disability, in favor of a more nuanced analysis of embodied life. It is not my intention to resurrect or reify this
binary by focusing on impairment, but rather to contribute to this move by furthering our understanding of the social, political, economic, and cultural aspects of somatic life.


13. I take the term *normate* from Rosemarie Garland Thomson. She explains “normate” as “the social figure through which people can represent themselves as definitive human beings . . . the constructed identity of those who, by way of the bodily configurations and cultural capital they assume, can step into a position of authority and wield the power it grants them.” See Rosemarie Garland Thomson, *Extraordinary Bodies: Figuring Physical Disability in American Culture and Literature* (New York: Columbia University Press, 1997), 8.

14. This is not to suggest that intellectual pursuits did not matter to self-making in the past, as they certainly did for many people, only that there were more spaces for intellectual diversity before the rise and subsequent dominance of Western-style education and the standardized testing that has accompanied it.


16. This Euro-American emphasis is an effect of the current trends in scholarship. Most disability studies scholars appear open to and enthusiastic about broadening their field geographically and culturally. See Kudlick, “Disability History.” Yet while four-fifths of the world’s disabled persons live in developing countries, there is a relative dearth of humanities and social science scholarship exploring disability in non-Western contexts. Important exceptions include Eric Silla, *People Are Not the Same: Leprosy and Identity in Twentieth-Century Mali* (Portsmouth, NH: Heinemann, 1998); Kohrman, “Motorcycles for the Disabled”; Kohrman, “Why Am I Not Disabled?”; Ingstad and Whyte, *Disability and ...


18. The Apgar test, designed by an American doctor in the 1950s, is performed immediately after birth to assess the infant’s physical condition and to predict the child’s developmental potential.


20. This is not to dismiss the clear class differences in technological and medical access within the United States.

21. This is a much different sensibility from the one that has dominated American culture since World War II. For more on the growth and dominance of the technological imagination in American bodily culture, see David Serlin, Replaceable You: Engineering the Body in Postwar America (Chicago: University of Chicago Press, 2004).

22. A more extreme contrast can be found in the case of live organ donors. Someone who loses a kidney through surgery in order to donate it to a relative is not constructed as disabled or as diseased, but rather as a gift giver, despite the fact that kidney loss can pose debilitating effects for the donor.

23. This is not to suggest that bodily aesthetics do not matter to people at all. For more on this, see Julie Livingston, “Aesthetic Impairments: Bodily Challenges to Sociability in Southeastern Botswana” (paper presented at the African Studies Association annual meeting, New Orleans, November 11, 2004).