MAT Medicine Anthropology Theory

## ARTICLES

### The protected lab: Securitization and spaces of exclusion in medical research in East Africa

*Denielle Elliott*

**Abstract**

This visual essay considers the links between medical research and securitization, and asks how they reconfigure local landscapes in East Africa. Humanitarian aid, including global medicine, has emerged as a 'military therapeutic complex', especially in African nations where the HIV/AIDS epidemic has drawn enormous contributions from states and transnational NGOs (Nguyen 2009; Fassin and Pandolfi 2010). One unintended effect of this therapeutic assemblage is a concern with security, particularly for US state institutions conducting research or providing treatment. US research facilities and laboratories are fenced, with access mediated by security guards and locked gates. State actors working overseas live in approved housing, bound by a complex set of regulations about safety and security. This essay and photographs reflect the ways in which physical structures transform local landscapes as part of the global health industrial complex and raise a number of questions about the politics of spaces, both private and public, in humanitarian projects.

**Keywords**

Medical research, securitization, Kenya, national science, sovereignty

> It's not so much that we're in danger, but that we're so terribly afraid.
>
> *A World of Strangers*, Nadine Gordimer (1958, 80)

#### Introduction

During fieldwork in Kenya, I was struck by the ascendancy of insecurity discourses in everyday conversations. Over dinner, one expatriate colleague told me how she knew of three expatriates who had been robbed in just the previous two weeks; another colleague who runs an AIDS nongovernmental organization (NGO) told me that her television had been stolen twice, as she lay


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in bed late at night. The metal bars on the windows were cut; she was dismayed that she had seen pipe cutters for sale at the grocery store. And yet another friend, a male Kenyan colleague, advised me it was best to drive as quickly as possible to get home in the evenings, to avoid being stopped by thugs. It is difficult to know to what degree these reports of insecurity might be inflated but, regardless, such discourses reflect local anxieties and fears among citizens and noncitizens working in East Africa. Concerns with insecurity also limited my access to particular regions of the nation. A permit from a provincial government body was delayed for over two weeks due to 'insecurity in the region' – a reference to local ethnic clashes between Pokot and Turkana nomadic herders, some armed with AK-47s, fighting in the South Turkana region. Then, on another level, the national media was dominated by conversations and stories about the postelection violence of 2007 and 2008, and the upcoming trials in the International Criminal Court, or ICC, of newly elected president Uhuru Kenyatta and deputy president William Ruto. And, lastly, a rise in grenade attacks in Nairobi and in the northeast, linked to Al-Shabaab, has resulted in increased security measures even in the local grocery stores (International Center for Transitional Justice Kenya 2010).

The idea that there can be 'no security without development and no development without security' has become a platitude that not only shapes the policies and practices of development but also those of global health and transnational medical research (Stepputat 2012, 444).[1] Anthropologists have highlighted the ways in which international humanitarian aid, including global medicine, has emerged as a 'military therapeutic complex', especially in African nations where the HIV/AIDS epidemic has drawn enormous contributions from states and state-like institutions in the global North, such as the US President's Emergency Plan for AIDS Relief (PEPFAR) or the Gates Foundation (Nguyen 2009; Fassin and Pandolfi 2010). Vinh-Kim Nguyen (2009, 198), especially, illustrates how the discursive construction of the AIDS epidemic as a humanitarian emergency and state of exception has resulted in 'unprecedented intervention on entire populations by NGOs and foreign powers', particularly in Africa (see also Nguyen 2010).[2] One unintended effect of this therapeutic and experimental

[1] CBC News 2008, http://www.cbc.ca/news/canada/story/2008/02/09/mackay-halifax.html, viewed 18 June 2013. See Makaremi (2010) for a discussion of Canadian policy and practice and humanitarian aid.

[2] As he and others have illustrated, this military–therapeutic assemblage transforms local biologies (Nguyen 2010; Gilbert 2013; Brotherton and Nguyen 2013) and local institutions (Hardon and Dilger 2011; Human 2011), and it creates populations and subjectivities (Sangaramoorthy 2012).

assemblage is a concern with security, particularly for states and multilateral NGOs conducting medical research, providing care and treatment, and rolling out new public health programs.

There is a growing body of scholarship focusing on the 'security–development nexus' and the ways in which development and humanitarian interventions are enmeshed with security practices.[3] For example, Mark Duffield (1997, 532) suggests that contemporary Western development policy reaffirms 'a form of sovereignty within the crisis regions' and that, in its attempt to offer aid, it contributes to political marginalization and instability. Simon Reid-Henry (2011) points out that the security–development nexus contributes to instability by discursively framing projects (including aid, humanitarianism, and global health) as matters of security, and he suggests that the scholarly focus on the 'nexus' may also reify the discourses that we are attempting to write against. These critiques help provide a setting for my argument by focusing attention on (1) the colonial resonances embedded within contemporary security practices in the global South and (2) contestations of sovereignty in humanitarianism (Duffield 2005).

In this article I explore the ways in which discourses of insecurity are instantiated within the context of global health projects. In focusing on securitization and the architectural interventions that are part and parcel of medical research and programming in Kenya, I hope to contribute to historical and ethnographic scholarship focusing on medical research in sub-Saharan Africa (for example, Crane 2010; Geissler 2005; Lyons 1992; Peterson 2014), especially those questioning the inequalities embedded in permanent transnational scientific institutions (for example, Fairhead, Leach and Small 2006a, 2006b; Farmer 2002; Redfield 2013). These studies highlight the inequalities that are inherent in complicated global health partnerships between sub-Saharan Africa and the West, and the ways in which such projects paradoxically attempt to address poor health and structural violence while relying on fundamentally exploitative and unequal relations of power (Crane 2010; Nguyen 2010). They also point critically to the historical continuities between colonial medical research projects and experiments in the tropics with new global health initiatives as well as to the ways in which local communities and nation-states engage with, resist, and imagine these projects (see, for instance, Lyons 1985; White 2000; Lachenal 2011).

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[3] For instance, on the security/development nexus, see Laliberte (2013); Avant (2007); Chandler (2007); Duffield (2005); and Reid-Henry (2011).

While these studies have deepened our understanding of the histories and politics of postcolonial medicine in East Africa, they do not account for the ways in which medical research and security practices merge to control and govern local cartographies of power. Sergio Sismondo (2004, 95) argues that ethnographies of laboratory spaces should not be strictly limited to those bounded by four walls (see also Latour 1988); thus, I seek to map the contours of what lies beyond those four walls and to understand how laboratory science intersects with geopolitical security in the global South. In what follows I examine the security cartographies of the scientific lab and clinic – from the rules and regulations set by the national centre in Atlanta, Georgia, to those enacted (at times selectively) in the homes of expatriate 'global health' researchers living on the shores of Lake Victoria in Kenya. In doing so, I speak more broadly to postcolonial public health administration and build on historical studies of tropical medicine, urban planning, and 'sanitary segregation' in Africa (see, for example, Curtin 1985; Otiso 2005; Murunga 2005; Overton 1987; Swanson 1977; Kennedy 1987). The material effects of these security practices bear a strong resemblance to the racialized patterns of tropical medicine and colonial settlements in Kenya more generally.[4]

This article emerges from a larger project that explores how HIV science and scientific practice disrupt, alter, and reconfigure landscapes and public spaces in Kenya.[5] US state institutions like the Walter Reed Project (WRP) and the Centers for Disease Control and Prevention (CDC) have large, scientific labs and medical research field stations in many parts of Africa. In Kenya, both of these state agencies have been conducting research on malaria, HIV, and tropical diseases for over thirty years. My inquiry illuminates the unexpected outcomes of the medical research that Northern states conduct in the global South, exposing the still-uneven flows and landscapes of transnational medical research – not to mention the contestations of sovereignty – embedded within the broader political

[4] In the spirit of critical self-reflection and historicizing research, it feels necessary to mention that, according to Philip Curtin (1985, 610), in 1913–1914 the London School of Hygiene and Tropical Medicine (LSHTM) initiated the 'most elaborate segregationist proposals, combining racist and sanitary objectives'. As a postdoctoral fellow with the LSHTM, I was aware of its colonial history in Kenya but not of these particular colonial segregation plans. This raises important questions about how scholarly institutions with racist, colonial pasts newly negotiate postcolonial landscapes, and the impact these histories might have on our own critical ethnographic practice.

[5] The photographs in this article were collected between 2007 and 2011, during postdoctoral research, which focused on the unintended consequences of medical research in western Kenya. For other photographic essays focusing on walls, see Wigoder (2010); Caldeira (2012); Andersen and Möller (2013); Yen-Ling (2011); and McGuire (2013).

and economic relationships between East Africa and the North (Das 2007; Nguyen 2010).[6] An examination of security practices, the surveillance of walls and gates that mark sovereign spaces within a nation, forces us to rethink Frederick Cooper's (2002) analysis of 'gatekeeper states' in postcolonial Africa. In the context of the protected lab, gatekeeping is both figurative and literal, enacted by Kenya's elite and imperial powers, both former and current, as each attempts to access, negotiate, and limit global flows in knowledge, resources, and bodies. Although many hoped that Kenya would emerge as an exception to the gatekeeping postcolonial state, that capitalism and democracy combined would free the state from its historical economic dependence on empire, contemporary Kenya remains largely dependent on foreign aid (noticeably, PEPFAR, the Global Fund, Gates Foundation, USAID, and the CDC), which is controlled by the political elite (Cooper 2002). This political-economic configuration – a political elite whose chief control is concentrated at the gate – weakens its ability to negotiate sovereignty within, particularly with foreign aid donors like the US Embassy.

My aim is to illuminate the assumptions, practices, and policies pertaining to danger, fear, and insecurity embedded within such state projects, and to consider the various ways that the North reconfigures security in the global South. In so doing I speak to the contradictions in what Ann Stoler (2006, 134) calls 'compassionate imperialism': the guarded walls surrounding lab compounds and researchers' homes mark the profound social inequalities that continue to plague global health research. How do such micropolitical acts in the areas of medicine and humanitarian aid reconfigure postcolonial landscapes? I explore security practices in transnational medicine as one form of contested statecraft in contemporary Kenya, a nation increasingly represented locally and globally as an insecure state; these issues are considered alongside a series of images that illustrate the material effects of security practices in western Kenya.

**Postcolonial landscapes**

East Africa has long been a preferred site for medical research (Neill 2012; White 2000). The Kenya Medical Research Institute (KEMRI), the national parastatal organization committed to biomedical research, has collaborations with state institutions and schools from all over the globe, from

[6] It does speak quite specifically to state-funded medical research. For more on American state medical research, see Reverby (2011) and Jones (2002). There is now an extensive body of literature on transnational clinic trials. See, for instance, Adams (2002); Cooper (2008); Petryna (2009); Rajan (2007); and (2011).

Cambridge to Nagasaki to Seattle. In the 1970s, under the leadership of Kenyan scientist Dr Davy Koech, KEMRI invited both the CDC and the US Army's research unit to work in Kenya and to collaborate with Kenyan scientists. The collaborations between KEMRI and the CDC, and other institutions from the North, are geo-biopolitical assemblages through which states attempt to manoeuvre for sovereignty and power while simultaneously framing interventions as exemplars of community collaborations, humanitarian aid and development, and local capacity building.

In the past twenty years we have witnessed a shift in the ways in which clinical research is carried out in resource-limited settings. Funding agencies demand 'collaborative' partnerships between researchers from the North and the South, and between academia-based researchers and community partners (community-based organizations and NGOs). International regulatory bodies, especially in AIDS research, mandate institutional capacity building in human resources and infrastructure as part of large transnational medical research projects. As a result, some foreign institutions have developed permanent clinical research field stations in the resource-limited settings in which they carry out trials. In Kenya, medical research and programs are funded almost exclusively by international donors – including the Gates Foundation, the Wellcome Trust, the Liverpool School of Tropical Medicine, the National Institutes of Health, and the CDC – and many of these donors employ their own citizens, or expatriates, in international field research settings. Though most projects commit to employing local labour and expertise, expatriates continue to be employed in senior administrative positions (as directors, researchers, managers), and they are often affiliated as graduate students and interns or seconded for temporary positions. These institutional settings alter local landscapes in a myriad of ways. New housing projects, new supermarkets, increased automobile traffic, new employment, along with the security practices that accompany them, are all productive effects, by-products of the labs and clinical spaces in which medical research is conducted.

CDC and WRP labs and medical research facilities in Kenya are gated, with access mediated by security guards, surveillance cameras, intimidating walls, and locked gates.[7] In 2001, the United

[7] Some comparisons could be made between the transnational medical research communities and 'enclave economies' as discussed by Ferguson (2005) and Watts (2004), as both appear to be 'territorial enclaves of [mineral] extraction are protected by private armies and security forces' (2005, 378). Yet, in the case of medical research, the large majority (at least 95 percent) of staff are in fact local Kenyans, and these are not corporate ventures but state-funded and state-run research centres. Furthermore, the complicated economic

Nations described Nairobi, the regional headquarters, as one of the most dangerous cities in the world and granted foreign staff living there additional hardship allowances (Abrahamsen and Williams 2005). This discourse of dangerousness is related to the history of al Qaeda and the bombings of US embassies in East Africa, and Kenya's strategic geopolitical importance in the Horn of Africa. Questions of security and safety are simply one part of a complex assemblage of logics and practices that constitutes global health research (Reid-Henry 2011), made more acute and complex since 11 September 2001 (Bonn 2005). Didier Fassin (2007, 2009) recommends that we be attentive to the local articulations and experiences of security and safety, and carefully attuned to the social cartographies that are altered, deployed, and constructed through discursive networks. He insists that scholars consider 'the multiplicity of links security has with other issues' (Fassin 2012, n.p.).[8]

Jean and John Comaroff (2000, 318) suggest that the nation-state has been 'rendered irrelevant by world-market forces' (see also Comaroff and Comaroff 2006), as clearly demonstrated in the global flows attached to pharmaceutical research and development. However, I want to suggest that, in East Africa, nationalist projects work *through* medical research and interventions. Although these security practices are distinguished by the neoliberal privatization of state policing and a proliferation of allied criminal economies, they replicate colonial borders and contagion strategies through segregation – by keeping out/in certain bodies and protecting others.[9] As Jan Bachmann and Jana Hönke (2010, 100) explain, 'as states that cannot control their territory are perceived as a security risk, Western governments have developed strategies that combine military interventions, building the capacities of recipient states' security forces, and development programmes.' How might we make sense of the entanglements of securitization, medical research, sovereignty, and development in Kenya?

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and bureaucratic agreements between the US Embassy (or in other instances the United Kingdom) and the Kenyan state necessarily transform these into state projects, unlike large-scale industry-sponsored research sites.

[8] In *Cultural Anthropology*'s (2012) virtual issue focusing on security. Also see Goldstein (2010), Ferguson (2005), and Omidian (2012) on the anthropology of security.

[9] On the history of spatial and residential segregation in East Africa, see Ndege (2001); Myers (2003); Christopher (1992, 1988); and Overton (1987).

This article is based on sixteen months of postdoctoral ethnographic fieldwork carried out in Kenya on an assortment of pharmaceutical clinical trials for HIV/AIDS prevention between 2007 and 2010. That fieldwork included participant observation within AIDS prevention trials, state- and university-funded projects, and a series of open-ended semistructured interviews (approximately 120) with staff, senior administrators, clinicians, community advisory board members, and scientists working from both East Africa and the coordinating centres in the United States. It is also based on two separate, but thematically related, postdoctoral projects, one with the London School of Hygiene and Tropical Medicine and one, funded by the Canadian Institutes of Health Research, with the University of British Columbia. I observed recruitment strategies, tracing and follow-up practices, pharmacy support, regulatory and ethics practices, staff training, staff retreats, community advisory board meetings, and the everyday administrative practices of running large-scale, multisited trials. For one of the trials I also spent time at the coordinating centre in the United States, at its biological storage facility, its administrative offices, and staff training seminars. Finally, I treated scientific conferences, where the results of these trials were presented and debated, as another site of ethnographic exploration.

I combine a range of materials collected from public sources (for example, community events and meetings, scientific lectures and conferences, news publications and recordings, grey documents, and e-mail lists) with private, and thus 'de-identified', materials from participant observation and interviews. Although my research focuses specifically on the politics and everyday practices of HIV trials, because these trials were part of larger medical research institutions and collaborations that encapsulated a spectrum of research projects (including malaria, tuberculosis, and tropical diseases), it also speaks to global health projects more generally.

*Walls as symbolic, Kisumu 2010*

**Discourses of (in)security**

Medical research is often carried out in nations such as Kenya, Uganda, and South Africa due to a complex set of factors including economics, presence of specific HIV strains, availability of drug-naïve patients, and relative political stability (compared to countries like the Democratic Republic of Congo, Sudan, or Somalia); however, international aid workers are still kidnapped and sometimes killed (Duffield 2010). The internationals employed by these Northern institutions, whether statist, humanitarian, or multilateral NGOs, are often framed as being at risk for violent encounters, and military analysts consider them to be 'soft targets' for terrorists (Rosenau 2004). East Africa and the continent more generally continue to be framed as dangerous spaces, plagued by random violence, criminality, questionable policing, terrorist cells, and insecurity (Comaroff and Comaroff 2006, 2000; Ferguson 2006). Yet, there is little evidence to suggest that American researchers or aid workers in Kenya disproportionately experience violent attacks. In fact, it is quite the opposite.[10] In 2007, Dr Job Bwayo, a Kenyan microbiologist and director of the Kenya AIDS Vaccine Initiative, was killed in Nairobi during a carjacking. Bwayo's wife and an American were also shot, but not killed, in the attack.[11] More recently, Dr Joseph Odhiambo, a Kenyan working as a senior technical advisor for

[10] It is highly unlikely given the nature of the security system – twenty-four-hour surveillance – that violent attacks on US Embassy staff would not be reported to one of these sources. In the past fifteen years, CDC security reports indicate two materially driven security issues in Kisumu – a senior American was robbed at a restaurant and another was car-jacked. Neither was physically harmed.

[11] See Peter Moszynski, 'Job Bwayo', *Guardian*, 23 February 2007. http://www.guardian.co.uk/news/2007/feb/23/guardianobituaries.kenya

the CDC in Kisumu, was killed on 27 October 2012 while waiting to enter his home in the Tom Mboya estate. It was the third murder in Kisumu in one week, following the murder of Shem Kwega, a local politician, which sparked riots in the area and the murder of a night guard at the Victory Church. The police blamed this spate of murders and violence on local gangs.[12] While theft is quite common, instances of expatriates being violently attacked in Kenya are very rare, and this illustrates how unevenly, and somewhat racially, the risk of violence is mapped in East Africa.

The material effects of these insecurity discourses, and the physical structures and everyday practices of security, mark the local landscapes in western Kenya. One of the ways in which these security measures transform landscapes is through walls and gates. Wendy Brown (2010) suggests that the wall is a symbol of declining sovereignty, a futile performance by a weakening state: part theatrical performance, part art, part engineering wonder, part architectural instrument, part illocutionary act. As a technology the wall does (or imagines doing) many things: excludes people, divides people, protects things, separates spaces, occupies territory, and declares ownership. The walls surrounding US Embassy labs and homes in Kenya do not reflect a loss of a geopolitical identity (or weakened sovereignty); rather, their discursive practices and material effects maintain and reinforce the sovereignty of foreign powers in Kenya, from the security of nations to the security of the expatriate body. It is a re-enactment and reproduction of the sovereignty of an imperial state through global health practices, rather than weakened by neoliberalism (Stoler 2006).

In Kenya, the structures that function as walls are many and varied: broken-down wooden fences, rock walls made from local materials, slabs of cement, chicken-wire fences that are barely standing, and so on. Some are just sheets of metal barely held together; others bear the colours of the Kenyan flag; some have informal advertisements for rabies treatment, Coca Cola, or NGOs; and then there are those meant to keep the hippopotamuses from getting into the garden. The more ominous walls have barbed razor wire and shards of broken glass meant to wound anyone who might consider climbing them. Some of the walls stand alone, but many are only a part of a larger, complicated security system. The systems may include panic buttons, alarms, and surveillance cameras. I was most interested in the ostentatious, most obvious performances of security: the highest walls; those

[12] Justus Wanga, 'Crime Wave in Town Linked to "Kisumu Mungiki"', *Daily Nation*, 4 November 2012, http://www.nation.co.ke/News/Crime-wave-in-town-linked-to-Kisumu-Mungiki/-/1056/1611026/-/item/0/-/l92hrg/-/index.html

with razor wire, electrical currents, and guards; and those that advertised that the property used two or three local security companies for protection and surveillance, as though one company alone would not be sufficient. Kenya's private security force remains one that relies on human resources for guarding properties and perimeter walls, unlike, for instance, South Africa, which has largely moved to technological security practices (Abrahamsen and Williams 2005).

*Local security measures, more creative, Kisumu 2009*

Security for medical research and programs is provided by private corporations, both local and international, rather than by state or public police forces. The privatization of security by the Kenyan state and the US Embassy is a distinguishing feature of postcolonial state relations in East Africa, or the 'outsourcing of the state' (Comaroff and Comaroff 2006, 16). Bedrock, KK Security, JRS, Securicor, and G4S – the latter traded on the London Stock Exchange – are just a few of the private security companies that provide services in Kenya. There are between four hundred and two thousand private security companies now operating in Kenya; a lack of regulation and licensing

makes it difficult to obtain precise estimates (Abrahamsen and Williams 2005). The industry has grown rapidly in recent years not only as a result of concerns about corruption in the state police force and a growing small arms trade but also because, in East Africa, Kenya is the regional site for many embassies as well as for humanitarian and transnational NGOs that have institutional mandates to protect their international workers. Yet, rumours circulate widely that security guards themselves, poorly paid and unarmed in dangerous work conditions, collaborate with criminals, are involved in home invasions, and steal the money they charged with transporting.[13] It would be an error to suggest that it is only expatriates who build these walls and hire these security forces. Faced with a public police force that has been weakened by structural adjustment programs and corruption, elite Kenyans also turn to private security companies that offer them walls, guards, and surveillance systems (something that is especially obvious in Nairobi).[14] Further, reflecting local tensions between African Kenyans and Indian Kenyans (and perhaps indicating an inherited vestige of colonialism), the affluent among the latter engage in similar practices and discourses.[15]

*Razor, Milimani, Kisumu 2007*

[13] Many are paid below the national minimum wage and report poor working conditions. For instance, see Moses Odhiambo, 'Police Hunt Suspects in Sh6.5 Million G4S Car Raid, 30 April 2013, http://mobile.nation.co.ke/News/G4S-loses-KCB-money-to-armed-robbers/-/1290/1762662/-/format/xhtml/-/11k8trcz/-/index.html (viewed 20 June 2013).

[14] I do not consider elite Kenyans' engagement, resistance, or responses to these foreign security practices in this paper but it is an important area of inquiry worthy of consideration in a separate paper.

[15] Ethnic and/class relations between Indians and African Kenyans is an issue requiring further exploration. For a discussion of Indian settler relations in colonial Kenya, see Murunga (2005).

Through medical research in Kenya, states are simultaneously configuring and performing security on multiple levels. These include political imaginaries, field stations, and intimate spaces of the home.

*Political imaginaries*

The history of Kenya as a space for al Qaeda, al-Shabaab, and the embassy bombings justifies the everyday security techniques of home and office, and politicizes the imaginary. The 1998 bombing of the US embassies in Nairobi (Kenya) and Dar es Salaam (Tanzania) resulted in an intensification of embassy security, and a prioritization of the safety of American citizens working in East Africa. On 7 August 1998 both embassies were bombed simultaneously, killing 224 people (most were East Africans, twelve were Americans) and injuring five thousand. The embassy attacks were linked to al Qaeda operatives. Four years later, another al Qaeda attack in Mombasa, Kenya, left fifteen dead at the Kikambala Hotel (Lyman and Morrison 2004). In 2003, former president George W. Bush increased security efforts in the region, announcing a US$100 million counterterrorism package as part of the US East African Counterterrorism Initiative (EACTI), which included US$10 million for a Kenyan antiterror police unit (Lyman and Morrison 2004).[16] Given the presumed al Qaeda infrastructure in the Horn of Africa, and the subsequent 9/11 attacks in New York, security measures were intensified for Americans working in the region, and this military logic has trickled down into the everyday state practices of medical research and aid. The US Department of State website frames the security question in Kenya for American expatriates as being multiple and very dangerous. Its approach to security for American citizens is distinct. For instance, in a comparative study of projects led by the US, United Kingdom, and Denmark, Bachmann and Hönke (2010, 104) found that the US projects in Kenya were 'more clearly driven by homeland security concerns and the development agency USAID has relatively little influence on these imperatives'. The framing of security in the region in relation to terrorism pre-dates the 11 September 2001 events in New York City (Rosenau 2005). The embassy website, which reports safety warnings to Americans travelling abroad, also focuses on political violence (in 2007–2008 and then again in 2012 and 2013), ethnic violence resulting from cattle rustling, and other kinds of danger, going so far as to state: 'US visitors to rural areas should be aware that close contact with children, including taking their pictures or

[16] US Department of State website, http://2001-2009.state.gov/s/ct/rls/rm/2004/31731.htm

giving them candy, can be viewed with deep alarm and may provoke panic and violence.'[17] Indeed, every space is considered a threat to the security of Americans working and living in Kenya, according to the US Embassy's website, which lists as potentially dangerous:

> Civil aviation (airplanes), maritime vessels, ports, police stations, police vehicles, nightclubs and bars, places of worship, religious gatherings, downtown buildings, small shops, bus stations, government buildings, university campuses, gathering places, public parks, rural areas, downtown areas, footpaths, beaches, poorly lit areas, residences, hotels, resorts, upscale shopping centers, restaurants, vehicles, schools, national parks, game reserves, and outdoor areas.

The website also lists the following unsafe geographical locations:

> Lamu Island, Dadaab refugee camp, Wajir, Garissa, El Wak, Madera, Liboi, Majenga, Saba Saba, Kisaui, Nairobi, Mombasa, provinces of Nyanza, Rift valley, North Eastern, Eastern, and Western, parts of Coast province (North of Malindi), Kerio Valley, Northern Rift Valley sections of Laikipia and Nakuru Districts, areas north of Mt. Kenya, game parks north of Mwingi, Meru, and Isiolo, Tana River Delta, Kisumu, coastal beach resorts, Samburu, Leshaba and Maasai Mara game reserves.[18]

In other words, in Kenya, you are not safe in any place or at any time. And for embassy security staff this was reaffirmed by the 21 September 2013 al-Shabaab attack on Westgate Mall in Nairobi, a shocking four-day scene of chaos, violence, and destruction, culminating in the death of sixty-seven people. The target: a mall in the upscale neighbourhood of Westlands, a community that is home to elite Kenyans and a large expatriate community. But it must be emphasized that these tragic acts, far from supporting more security or more surveillance strategies, in fact point to their futility and failure.

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[17] US State Department website, http://travel.state.gov/travel/cis_pa_tw/cis/cis_1151.html#safety

[18] From http://travel.state.gov/travel/cis_pa_tw/cis/cis_1151.html

*Home security, Milimani, Kisumu 2009*

Unofficially, one of my CDC colleagues who worked in the Atlanta CDC office told me that, for each US citizen employed in East Africa, it cost approximately $US50,000 per year for security measures. The security practices begin before citizens leave the United States. Aid workers and state actors working overseas receive security training in preparation for their international placements, are warned about the dangers of working overseas, and are expected to review the rules and regulations. Employees of the CDC and the WRP working in medical research and programs must participate in a seminar on international security practices and policies. They are advised on professional etiquette, everyday conduct, housing, intimate/sexual relations, transportation, and the various guidelines for emergency measures and security threats while living in East Africa. Katie, a CDC staff member seconded to Kisumu for a three-month position, recounted having had dinner with another CDC employee a few nights before and that the woman had violated all the basic security rules they had learned. When I asked how, she explained that her colleague had been smoking and talking loudly, and had publicly stated that she was an American working for the CDC. Kate explained that, during CDC security training, staff members were instructed not to let locals know that they were Americans.

The embassy security policies are bifurcated.[19] The rules for expatriates differ from those for local Kenyan CDC/KEMRI staff. In 2008, US Embassy staff were forcibly evacuated during the postelection violence, while Kenyan staff were left to fend for themselves. There were rare cases of American researchers taking personal risks, against embassy orders, to help local Kenyans escape violent situations; however, generally, such institutional policies are emblematic of the privilege of mobility for expatriate researchers (Redfield 2012). Atlanta administrators reprimanded an American research director working for the CDC for refusing to leave when the embassy demanded an evacuation of US citizens during the 2008 postelection violence in Kisumu; this was a personal act that not only challenged the inequality inherent within institutional practices but also contested the discourses of insecurity being circulated by the US Embassy. This staff member reflected on the irony that, as they were being driven to the airport to be evacuated because of supposed local political instability and violence, they passed the golf course, where local Kenyan elites continued to play – for him, this demonstrated that the local situation was not as dire as the US Embassy imagined it to be. As Fassin (2007, 500) explains, these distinctions between expatriates and nationals, which may appear to be simply bureaucratic, are reflective of a much deeper, troubling rift between North and South, a rift that speaks to the 'dialectic between lives to be saved and lives to be risked'. Stereotypes about Africans and Americans are embedded within the logics of these US state policies and practices: Kenya is a dangerous place, especially for Americans.

*Field stations*

In Kisumu, there are a handful of medical research field stations, all of which are partnered with KEMRI. But others, including the Lumumba site (site of medical research collaborations with the University of California, San Francisco; the University of Illinois-Chicago; and the University of Manitoba, among others), the Danish Division of Vector Borne Diseases, and the Impact medical research site do not share the same walling, guarding, or security practices even though these sites have multimillion-dollar budgets and large bioscientific research programs. Although home security practices may be individually adopted by expatriates or Kenyans working for these organizations, they may choose what security measures they adopt and American expatriates working at these sites can choose to live where they please. CDC and WRP labs and clinical research centres are more

[19] Didier Fassin (2007) has similarly illustrated this with Médecins Sans Frontières. In both cases, the distinction between nationals and expatriates is not limited to questions of security but, rather, cuts across housing, benefits, salaries, and opportunities.

guarded than any of the other clinical research centres. Although the former director of KEMRI insisted on less security and more open and inclusive research centres, this request has been largely ignored by the US State Department. The amount of financial aid being directed from the United States to Kenya through the CDC, the US Army Medical Research Unit, and PEPFAR has granted the US State Department a certain immunity, enabling it to carry out projects according to US policy and to ignore local customs or preferences. This has left local state authorities little leverage with which to negotiate.

The CDC and the US Army Medical Research Unit have clinical research centres located in Nairobi and multiple sites in western Kenya. Local site practices are subtly different, but all sites are intensely guarded and treated as though they are embassy territory. The general processes involved in entering are illustrative. At an initial guarded gate you are asked to provide identification. You then proceed to the next gate, where you are again asked to provide identification, and to sign in, indicating whom you are visiting. Once you have entered the grounds (assuming you have the right credentials to make it through), if you want to enter the CDC building, you must be buzzed in through a locked door before being allowed in by security staff located inside of the building. You must sign in, provide a security guard with your name, hand over identification, and state the purpose of your visit, your time of arrival (and departure), and your phone number. You are provided with a visitor's badge and an escort must accompany you. Within the building, the doors lock automatically, so you need someone with an electronic badge to let you in (and out). Guests are not permitted to take photographs at these sites, either inside or outside. In contrast, on the very same grounds, the national medical research office is open and you are free to walk straight to the director's office. There are no requirements, no badges, and no stern security guards.

*Kenyan flag, Milimani, Kisumu*

Under the complex agreement between the US state and KEMRI, security is the responsibility of the Kenyan government. The government contracts it out to private security corporations who guard the field station sites and private homes of American citizens working in East Africa; in Kenya, this is the exclusive domain of KK Security. KK Security is one of the largest private security firms in East Africa, with over five thousand employees in Kenya alone and offices in Burundi, Rwanda, Uganda, Tanzania, and the Democratic Republic of Congo. Their contract with the US Embassy includes over 750 guards, staffing embassies, research centres, and homes of American citizens (Abrahamsen and Williams 2005). It is a very dangerous job in Kenya, and one estimate suggests that between five and ten guards are killed each month (Bonn International Center for Conversion 2005).

The perimeter walls around research stations and the techniques of security are very important markers at the level of the political imaginary (Brown 2010). While it might be common for scientific labs to be guarded, regardless of their location, this is at odds with the rhetoric of compassion, integration, and collaboration that characterizes contemporary global health research. The KEMRI collaborations with the CDC and the WRP focus on diseases of inequality – HIV especially, but also malaria (easily prevented with mosquito nets), TB (linked to poor social conditions and HIV), and rotavirus (diarrheal diseases resulting from poor access to potable water) (Nguyen and Peschard 2003). Embedded within state projects that aim to address global health inequalities are practices that reify the very same historical inequalities they seek to address. These practices of walling – a

securitization if not a militarization of medical ethics and practices – hinder our attempts to address inequalities and certainly obstruct any possibility of a democratic global science. Although many researchers are acutely aware of this inherent paradox in their work and institutions, it has become so normalized that it is rarely seriously challenged.

*Domestic spaces*

In the early twentieth century Kisumu, Kenya's third-largest city after Nairobi and Mombasa, was an important township, being a major inland port on Lake Victoria and located at the head of the railway (Whitehouse 1902). Known originally as Port Florence, it was formally established in 1904 as one of two municipalities in the British East Africa Protectorate. Under British East Africa, the region drew administrators and settlers who were granted land as private estates and farms (Okoth-Ogendo 1991). The regions adjacent to Kisumu, located on Winam Gulf, were the sites of malaria, blackwater fever, and a sleeping sickness epidemic that at the turn of the century killed thousands. However, it was a 1904–1905 outbreak of bubonic plague that shaped 'urban' colonial health policy (East Africa Protectorate 1905; Ndege 2001). The bubonic plague was blamed on the movement of infected individuals into town, and the subsequent colonial solution was to create segregated residential zones according to race (Ndege 2001). Kisumu was divided into three living areas with the intention of limiting cross-contagion between populations. Milimani, which overlooks the port and railway, was home to the Europeans. The Indian Quarter (or Bazaar) was designated for Asians. On the outskirts of town was the third area, designated for Africans. Otiso (2005) describes colonial policies under British rule in Kenya that excluded Africans (and in many cases Indians as well) from particular urban spaces, declared specific areas unhygienic for European settlers, and established legislation that prevented Africans from owning land and, at times, from working in urban centres. He suggests that, after independence in 1963, these exclusionary practices were maintained, although they evolved from being a racially based to a class-based form of segregation, which continues to have ill effects on the majority of poor Kenyans today. Current configurations of domestic housing for expatriates, Kenyans, and Indians echo colonial policies of urban planning and quarantining.

Today, Milimani, which borders the growing and intensely overpopulated and under-resourced Nyalenda housing projects, continues to be the home of Kisumu's elite. Milimani has evenly paved streets, the grass is green and always manicured, and the flowers are lush with fragrant blooms, especially after the rainy season. It is filled with immense homes surrounded by fences, private

security, and guard dogs. Here the US state's jurisdiction works itself into American citizens' homes in East Africa as it designates approved zones for living and suitable housing. How do medical researchers reconcile principles of care and collaboration with the segregating walls and security measures of the institutions in which they work? Many of the researchers and medical staff working for the CDC and the WRP indicated that they were motivated so by a politics of compassion, their concern being to address the devastating impact of AIDS and/or the inequities in global health and to 'save lives'. Humanitarians, leftist activists, poverty advocates, medical doctors, anthropologists – many of us are drawn to work, activism, and research in global health and imagine a world free of borders and barriers, and yet we often must live with institutional policies and practices that contradict those principles (see Feldman 2007). At times, this might include gated communities whose physical barriers exclude, discriminate, and enact oppressive political will.

American CDC and WRP researchers are cut from many cloths; some were obviously uncomfortable with the security measures they were compelled to obey, while others, like Sarah,[20] saw them as necessary. Before leaving the United States Sarah was provided with a portable door alarm, a device that she hung on the doorknob so that, should an intruder open it, a loud alarm would sound.[21] These devices had to be returned to the office at the end of her secondment. She was vigilant about following the regulations set forth during her security training with the CDC. There are many similarities in security practices among elite (white and black) Kenyans, Asians, and the expatriate community, but those mandated by the US Embassy are not elective, and they are specifically at odds with the discourses of cooperation and collaboration in contemporary medical research and aid.

US Embassy staff are required to live in embassy-approved housing located in embassy-approved areas. In Kisumu, all embassy-approved homes are located in the neighbourhood of Milimani, the historical residence of British colonialists, then of elite South Asians, and now of US Embassy employees, other expatriates, and elite Kenyans. The homes are gated residences guarded by staff

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[20] Names have been changed to protect identities.

[21] In *Islands on White*, his history of white communities in Kenya and the former Rhodesia, Dane Kennedy (1987) recounts a fictional story by Doris Lessing of Mrs. Knowell and her habit of sleeping with a locked and barricaded bedroom door (and a revolver under the pillow). Expatriate staff practices of locking the metal bedroom door, or hanging the motion-sensor alarm on bedroom door handles, while new performances of segregation and security, are certainly a vestige of these historical practices.

from KK Security; most have immense metal gates, electrical and/or razor-edged fencing, guard dogs, and panic alarms. US Embassy homes are often easy to identify by the security company vehicles sitting outside of the gates. Like entry to the field stations, entry to a CDC employee's home requires showing identification and receiving permission to enter the property. Even the interiors of the homes are governed by US Embassy rules. For instance, it is mandated that bedrooms must have internal-locking steel doors. When I asked one CDC employee about this, she surmised it was a precaution should there be a political coup. Social events at the homes of CDC administrators and researchers come with increased security measures: extra guards, a list of invited guests, and yet more KK Security cars parked at the entrance. I found it uncomfortable to walk past reinforced security gates in order to attend these 'expat' parties; however, for most embassy workers, it was normative, just part of everyday life. To me, such extreme security measures appear to be a dramatic overstatement, an exaggerated performance of imperial privilege that is less about security and more about exclusion, about stating who is not allowed to enter.

*Total surveillance, Kisumu 2010*

However, these practices are taken up unevenly as both expatriates and white Kenyan citizens alike resist replicating colonial practices, in attempts to reconfigure relations with black Kenyans that atone for historical violences (see, McIntosh 2014). Acutely aware of the global critiques of Western privilege and colonial oppression and exploitation, both awkwardly attempt to map out a space in contemporary Kenya for work and life.[22] For expatriates, work and home are governed by institutional policies and practices that they are unable, even when willing, to resist without fear of dismissal or a punitive mark on their employment file. White Kenyans, on the other hand, might self-segregate, choosing to live in affluent, mixed neighbourhoods like Milimani in Kisumu. Both cases demonstrate what McIntosh has referred to as 'structural oblivion', meaning the lack of self-awareness of how one is complicit in relations of power, 'no matter how well-meaning they may be' (2014, 1164). Expatriates attempted (often, but not always) to reconcile their willingness to follow the security rules and regulations that they acknowledged as oppressive or exclusionary, by either blaming their own nation state or, more often than not, highlighting it as a 'necessary evil' in the delivery of aid and humanitarian support and in 'saving lives'. While traces of colonial practices and discourses about danger, insecurity, and violence remain in the workplaces and lives of expatriates working in medicine in Kenya, many do engage with the local Kenyan community in ways that many white settlers historically did not. Among the expatriates working in Kenya who were encountered during this research, there were those who had intimate affairs with local Kenyans (men and women), married Kenyans, gave birth to Kenyan children, legally adopted Kenyan infants, and eschewed the 'expat scene' to form meaningful friendships with Kenyans outside of work, but all such relations pushed up against the embassy's institutional technologies (discursive and material) that sequester expatriates from local Kenyans. This is similar to the contemporary case of young, white Kenyans who make an effort to realign themselves as 'good Kenyan citizens' in part by relating to locals black Kenyans in new ways (McIntosh 2014).

Over the years I have collected numerous photographs of these guarded gates, and I am always struck by the enthusiasm of the security guards, the *askari*, who proudly pose next to them to have their pictures taken. On one level, this seemed strange and not a little sad, given that, being poor Kenyan men, these gates are essentially designed to keep them out. And yet, like Kenya's political

[22] Although there are some similarities to be made between white Kenyans and expatriates, especially those that have long-term placements in Kenya (up to eight years), Janet McIntosh points out that white Kenyans clearly distinguish themselves from 'Two-Year Wonders' (McIntosh in press).

elite who benefit from their role as gatekeepers at the national level, the *askari* too accrue social and economic status as the guards who govern and protect Americans, Kenya's elite, and their families while they stand astride both the local territory and the cosmopolitan other.[23] And while it is a dangerous occupation, it is at least a paid position in a nation that suffers from an unemployment rate of 50 percent, or more, and a space that provides access to external global economies. In this context, the gates that they man both include and exclude their own (Kenyan) bodies, providing access to international visitors and the global health research apparatus, and yet governing their place outside of the labs, clinics, and domestic spaces of expatriates and elite Kenyans.

*The US Embassy bedroom door, Milimani, Kisumu 2009*

**Sovereignty and national politics**

Given the 2013 Kenyan presidential election, this is a particularly interesting moment in history to

[23] I'd like to thank one of the anonymous reviewers for making this important point.

be writing about sovereignty and the relations between Kenya and the North. Uhuru Kenyatta and running mate William Ruto, now elected as president and deputy president, respectively, are two of the politicians whom the International Criminal Court (ICC) has charged with having committed crimes against humanity in the postelection violence of 2007 and 2008. Many have suggested that the ICC charges helped them win the election, as Kenyatta used the ICC charges as way to position himself against imperialism, announcing that he and Ruto were 'reclaiming sovereignty' from 'foreign powers'. In a December radio interview, Kenyatta stated: 'As I see it, they are trying to colonise us by imposing a certain leader on us because that leader will provide them with what they need.' His speech on 9 April 2013 at the presidential inauguration directly addressed national sovereignty and Kenya's relations with the West: 'We expect the international community [to] respect the sovereignty and democratic will of the people of Kenya. The African star is shining brightly and the destiny of Africa is now in our hands.' These are symbolic performances whose purpose is to curtail the barriers limiting access and power in Kenya. Yet, at other moments in history, Kenya's elite have prospered by accepting Western political and economic interventions. His father Jomo Kenyatta, for example, was known for his pro-Western and capitalist political vision for the country; Daniel Arap Moi, on the other hand, resisted Western-imposed visions for the nation. Regardless, Kenya has not been able to achieve financial independence, relying heavily on gifts, loans, and foreign aid, especially for HIV/AIDS and medical research infrastructure (Hornsby 2013). This pattern of aid continues, but now includes foreign loans from China and other Asian investors as well.[24]

Such conflict is also reflected in recent shifts in the management of the international collaborations between KEMRI and the CDC. In such collaborations, as Duffield (1997, 532) notes, '[w]hile formal sovereignty is upheld, it is reshaped to create the space for an emerging pattern of external involvement'. One former senior KEMRI official described the Americans' administrative style as 'very forceful', characterized by 'micro-management' of the local administration, and justified by the Americans on the basis of their fiduciary responsibility to 'American tax-payers'. Seemingly mundane complaints that CDC research vehicles did not have KEMRI signs on them reflect the continuous political manoeuvring and contestations over sovereignty that play out through government-funded medical research. Administrative changes have followed complaints from senior KEMRI

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[24] See, for instance, Dorothy McCormick (2008).

administrators regarding the CDC's control over fiscal matters, such as requiring CDC approval for expenditures. In one recent case, the CDC field state branch chief position was redefined as consultant to a KEMRI (read 'African') director. These recent administrative changes may be reflective of the influence of new aid-and-trade partners from East Asia. No longer dependent upon the United States, with new emerging global economies in the East undermining the economic power of the North, perhaps Kenya's political elite no longer feel they have to tolerate the demands and practices of the US Embassy or the CDC. These new partnerships, however, will create another set of tensions and political expectations that Kenya's elite will need to negotiate (Comaroff and Comaroff 2000).

*A local askari, Kisumu 2011*

**Conclusion**

The colonial discourses of bodily contagion that rationalized urban segregation and exclusionary practices in the early twentieth century are reiterated in a discourse that focuses on a different type of threatening body: the terrorist African. No longer excluded because of theories of contagion, Africans are now excluded from embassy labs, clinics, and homes due to policies and regulations that deem them a security threat to American nationals and nationalist projects. It is difficult not to read a racial subtext into these government insecurity discourses and physical artifices. The framing of expatriates as at risk, and the surveillance and security measures that follow, reproduce a context of exclusion, mistrust, discrimination, and fear – of spaces, peoples, and bodies. This situation then paradoxically demands further security measures, which creates more fear, which requires additional security measures, and so on, ad infinitum (Reid-Henry 2011). These practices and discourses

contribute to the politicization of medical research and exclude particular types of bodies. They reinforce uneven relations of power, reminding Kenyans of their marginal status in comparison to that of the US state, and they reinforce the marginality of both Kenyan science and the Kenyan state in relation to 'global' medical research (Stoler and Cooper 1997). These security practices are disproportionate performances that, on a daily basis, remind Kenyans of the power, privilege, and prestige of the US nation state.

Paradoxically, security for the CDC and the WRP is provided by private corporations contracted out by the Kenyan state through the complex bureaucratic agreement between the US Embassy and KEMRI. The embassy's demand that American citizens in Kenya be protected from Africans relies, in part, on Kenyan men, who are underpaid and who take great risks in a nation in which reports of poverty-driven crime are on the increase. As relatively poor and underpaid African men, they enact policies that limit their access to spaces that Americans have carved out – labs, clinics, homes – in their own nation, and they do so amidst discourses of insecurity that frame them as threatening and dangerous. US Embassy staff are cordoned off into elite neighbourhoods or into workspaces where they are forced to abide by security policies that limit their personal and professional lives and that feed fears that they are at risk, when there is little evidence to suggest that this is the case. This increased militarization of both global medicine and East Africa by the United States enables security to creep into intimate spaces, homes, and workspaces in unprecedented ways.

The world certainly does seem to be more and more focused on insecurity, in all its forms, and this is not limited to developing nations. As anthropologists we work in many social landscapes that others would consider 'insecure'. At York University in Toronto we receive e-mail alerts reporting violent crimes on campus or at the nearby intersection of Jane and Finch, reports that are often disturbingly racialized. It is not my intention to downplay questions of security. From Kenya, I recently received an e-mail from a Kenyan friend in which he commented: 'We're going through another cycle of ugly insecurity right now.'[25] More than most I am aware of what dangers fieldwork may inadvertently bring.[26] As researchers we, too, must attempt to reconcile safety, anthropological praxis, and housing in the field, and we may seek out security guards or guarded homes. However,

[25] Received 15 June 2013.

[26] During fieldwork in 2009, I was physically attacked at night, and sustained life-threatening injuries.

some of the most intensely guarded homes in Kisumu and Nairobi are still broken into; US Embassy staff are still robbed in their cars, in hotels, and in restaurants as they socialize over dinner. We must be mindful that, when these walls and security practices occur as part of international medical research projects, they function as mechanisms of state power that reiterate historical legacies insidiously by constructing difference between bodies to be protected and bodies that threaten.[27]

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**About the author**

Denielle Elliott is an Assistant Professor in the Department of Social Science at York University, with cross-appointments in the graduate programs of Anthropology, Development Studies, and Science and Technology Studies. She is a founder and co-curator of the Centre for Imaginative Ethnography, and writes on questions relating to postcolonial science, marginality, and experimental medicine.

[27] Of course, because we, too, as anthropologists abroad, might depend on them (if only for their imagined safety), it is difficult for us to be critical of such practices. But we must, because they are part of the way in which North/South collaborations and practices of humanitarianism continue to be inequitable, uneven, and at times discriminatory.

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