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"Western Influence, Latent Racism, and their Impact on Access to Health Care in Madagascar"

While the Malagasy commemorate their Independence Day on June 26 as the day they were freed from colonization and allowed to function as their own country with their own cultures and practices, colonization and Western influence has left an indelible mark on Madagascar that continues to exert its power to this day, shaping Malagasy social behaviors, values, and lives. The introduction of the slave trade to Madagascar in the mid-1800s, as well as French colonization, has left behind a thriving latent and structural racism in the country; a Western ideal of beauty, made complete by its valorization of fair skin, continues to permeate Malagasy life through advertisements, TV, movies, and music, contributing to a preference for Indonesian heritage and appearance. Additionally, the introduction of allopathic medicine and an economics-based health care system to Madagascar by the French continues to function as the primary system despite its failure to meet all the health care needs of its people. But while a great percentage of the Malagasy population cannot stand to benefit from purely allopathic remedies, *mainty*, or "blacks," in the highlands might be said to be at an even greater disadvantage to access needed health care services and medication because of their underprivileged position in society. Furthermore, their ability to physically access allopathic care may be undercut by their greater concentration in rural communities with less physical access to hospitals and allopathic facilities. As a result, *mainty* may be more likely than their *fotsy* ("white") peers to turn to more accessible, less expensive traditional medicine practices—but even traditional medicine has not been free from Western influence, facing illegalization, de-valorization, and demonization due to

promotion of Christian and Western values. Such a de-valorization may negatively impact *mainty* who, because of their greater lack of resources, need traditional medicine to reasonably meet their health and economic needs, further undermining their ability to successfully access needed health care services and to live long and healthy lives. There is no doubt that the introduction of these Western alternatives has worked tirelessly to alter the native Malagasy people, promoting Western ways of life while de-valorizing traditional Malagasy ways of life in the process and socially shaping the dimensions of health in Madagascar, be it through the health care systems or the Malagasy's relationship to them.

A Brief History of Slavery in Madagascar

While there is ongoing debate as to the origins of the Malagasy, the best evidence suggests that Madagascar was first populated between 600 and 800 CE by voyagers from what is now known as Indonesia (Graeber, 2007: 33). After King Andrianampoinimerina (1789-1810) managed to unify a previously warring Imerina into a centralized state, his son, Radama I (1810-1828), was approached by British envoys and offered recognition as king of Madagascar if he agreed to outlaw the export of slaves (Graeber, 2007: 33). In addition to this, the British agreed to provide money, a civil service, arms, military training, and missionary teachers for the creation of a school system in Madagascar (Graeber, 2007: 33). Radama I accepted the offer, and as a result, slaves began to flow into the country instead of out of it, creating a population of what would later become the ancestors of *mainty* in Imerina (Graeber, 2007: 34).

While the Merina government had hoped to recreate an alliance with England in the following years, their efforts proved for naught when in 1895, a French expeditionary force marched on Antananarivo and subsequently colonized Madagascar (Graeber, 2007: 34). A year later, in September of 1896, the French issued a decree proclaiming the official abolition of

slavery in Madagascar, leaving former slaves with three options: they could (1) return to their original regions, (2) leave for new territories, or (3) stay in the villages of their ancient masters (Razafindralambo, 2005: 1-2). Ultimately, the majority of former slaves who chose the final option found themselves faced with persistent problems of discrimination and identity formation, never truly gaining a full and equitable absorbance into the greater population (Razafindralambo, 2005: 2).

***Fotsy, Mainty,* and Latent Racism**

Today, *fotsy* ("whites") and *mainty* ("blacks") make up the two main social categories of Merina society, with *fotsy* described as having light skin and smooth hair, or otherwise more Indonesian traits, and *mainty* described as having dark skin and frizzy hair, or otherwise more African traits (Solo, 2011). *Fotsy* are believed by the Merina to have their origins in the Indonesian royalty that existed during the Malagasy monarchy; *mainty,* on the other hand, are believed to be the descendants of ancient *andevo*, or slaves (Solo, 2011). This difference in origins contributes to the still-functioning latent racism in Imerina, preserving the imperialist racism that justified slavery in the first place by perpetuating a belief in the biological inferiority of those who are more African in appearance (Solo, 2011). While a mix of these traits also certainly exists among the population, it would seem that those who can "pass" as *fotsy* experience less latent racism than those who fall under the *mainty* category.

Latent racism also has its roots in French influence, which created the political divide between highlanders and those in rural communities through the French's valorization of the highlanders' fairer skin (Solo, 2011). During colonization, highlanders received preferential treatment by the French through the supply of schools, roads, and hospitals to their region; highlanders were also employed by the French to function in important state and medical officer

positions, gaining much higher economic benefits than their Malagasy counterparts (Solo, 2011). Where medical officers were concerned, these benefits often led to the abuse of patients and disinterest in the health problems and needs of the population; as these medical officers were often posted to coastal and rural areas, they became representatives of French rule and subsequently bred resentment towards the highlanders among the other regions (Solo, 2011). This resentment has continued to linger despite Madagascar's liberation, resulting in instances of sporadic violence in more African, coastal areas against those more Merina in appearance (Leithead, 2002). While the French are no longer in control of Madagascar, their influence remains: an economic divide persists between the highlands and other rural regions, just as an economic divide persists between the *mainty* and *fotsy* populations of the highlands itself (Solo, 2011).

Examples of Latent Racism: Persistent Western Influence and Stereotypes

Despite Malagasy's eagerness to distance themselves from the French, Western influence continues to function and impact the quality of *mainty* and *fotsy* lives in Madagascar on a daily basis. French continues to be the language of instruction in schools, de-valorizing the Malagasy language and disadvantaging those who do not or cannot learn French, particularly residents of rural communities who have less access to schools than highlanders (Solo, 2011). Western movies, music, and TV programs have a strong presence in Madagascar, perpetuating, among other things, a Western ideal of beauty: fair skin, smooth hair, big eyes, and small, precise features. Malagasy advertisements on TV and on billboards around Antananarivo can be seen to reflect these same valorizations, predominantly depicting lighter-skinned, smoother-haired Malagasy who are more Indonesian in appearance, or, in some beauty advertisements, simply depicting white, Western women. Beauty advertisements and products claiming to improve one's

appearance perpetuate an improved appearance as a Western one: specific shampoos to soften one's hair, hair dyes to lighten one's hair, eye makeup to "open up" or otherwise exaggerate one's eyes with most products sporting white, Western models on their packaging. Beauty ads like these can be seen as reasonably contributing to persistent stereotypes, uncovered by one SIT student's conversation with her family, about darker-skinned, more African Malagasy as "ugly," unattractive, undesirable, and thus less valuable than their more Indonesian counterparts.

In addition to Western influence, relations between *mainty* and *fotsy* can be seen as reflecting this latent valorization of fair skin. In one instance, an SIT student's family relayed how a neighbor of theirs had become depressed when her son, the fairest-skinned of her children, fell in love with and married an "*andevo*" (what is now a racial slur for *mainty*). They also confided that "*andevo,*" a slur they repeated in hushed tones, were often poorer than their "white" counterparts and were more likely to hold low-paying jobs. Another student confided that her own family claimed that Malagasy women would often search for white husbands online and that Malagasy want to marry people paler than themselves.

But latent racism and Western influence does not only affect the lives of *mainty* and *fotsy* in Antananarivo and other urban communities; as *mainty* tend to be more concentrated in rural areas (which are more often poorer areas), an urban disdain for rural communities and the lifestyles associated with them exists as well. Examples of these urban-rural racial relations appeared in communications with my homestay families, both in urban Tana and in rural Andasibe. In discussing with my Tana family the recent election of the U.S.'s first black president, my homestay sister asked me if there had been a lot of controversy about it. When I said that it had been a huge milestone for racial relations in the U.S. but that there certainly had been racist opposition within the country that continues even now, she proceeded to tell me that

"it's the same [in Madagascar]," that if Madagascar elected a president who was "from the country" that there would be a lot of "controversy and discussion." Similarly, upon my return from Andasibe, my Tana homestay siblings were eager to know if the people there were "bizarre" or if they spoke any French at all, suggesting an assumption of rural villagers as uneducated and strange and a belief that only knowing Malagasy denoted a lack of education and stupidity. As another example, one of my uncles in Andasibe, fairer-skinned and softer-haired than the majority of his relatives, was known around town for "making it out" of the community due to his studies and opportunity to work in Italy. That he was known for such a feat was revealing in that it alluded to a de-valorization of rural life, suggesting that one's goal in a rural community should be to meet success by "making it out" and distancing oneself from her or his rural roots. Interestingly enough, in introducing me to one of his younger brothers who was much darker-skinned than he, he confided with some laughter, "This is my brother. He is black. Not like me." Similarly, a particularly lighter-skinned, Merina-looking pharmacology student confessed that she would often get called a *vazaa*, or foreigner, in Andasibe, alluding both to the rural community's greater *mainty* population and to the somewhat strained racial relations that exist between *mainty* and *fotsy*.

Connections to Health

A persistent valorization of fair skin via the media and social relations coupled with an economic divide between *mainty* and *fotsy* suggests that the existing latent racism is institutionalized, making *mainty* socially subordinate to *fotsy* and subject to a lesser quality of life. An economic divide between the two groups also renders *mainty* economically underprivileged, a factor that would directly affect their access to health care services in an economics-based health care system.

Currently, the allopathic health care system in Madagascar, like in the U.S., exists as a business and ultimately aims to make a profit. Private hospitals and practitioners offer a better quality of care and attention at higher rates, leaving those with fewer resources less opportunities to meet their health care needs, and even public hospitals offering free service require money for medication (Private and Public Hospital Excursions, 2011). Research and development of allopathic remedies and treatment comes at an enormous cost, resulting in expensive drugs that the impoverished simply cannot afford even if they can receive free diagnoses from primary care centers (Andriamparany, 2011). While such a system negatively impacts all Malagasy who are not greatly economically privileged, it can disproportionately affect *mainty* who, because of their subordinate position in society, are more likelier than their *fotsy* counterparts to be unable to afford health care. Similarly, because *fotsy* may be more likely to have the resources to train to be health practitioners, *mainty* may even face discrimination in attempts to access a *fotsy* and highlander-dominated allopathic health care system.

Certainly, *mainty* could be disproportionately affected by a major lack of access to allopathic health care in rural areas because of their greater concentration in rural communities. In many rural areas, there are no roads or ambulances and no health centers within a reasonable distance (Rasamindrakotroka, 2011). As an example of such limited rural access, one CSB primary care center in Andasibe was cited as providing one phone number and ambulance for the entire district, which consists of approximately 250,000 people (CSB Excursion, 2011). The same center was minimally staffed with one doctor who relayed that only about 5-6 children in the entire district come in for annual preventative check-ups, suggesting that there is a lack of ability to access at least preventative care (CSB Excursion, 2011). Perhaps most disconcerting is the fact that there is an abundance of qualified, trained medical doctors in Madagascar, but that

such a huge insufficiency in personnel still exists because doctors are heavily concentrated in urban areas; currently, many doctors have no interest in practicing in rural areas and some even train with the intention of practicing outside of Madagascar altogether (CSB Excursion, 2011); (Rabarijaona, 2011). This lack of personnel could reasonably be linked to latent racism, as *fotsy* and highlanders who have more resources and privileges to train to be health practitioners might prefer to practice in their own highlander communities than retreat to *mainty*-dominated rural areas.

This lack of access would reasonably lead more *mainty* to rely on traditional medicine to meet their health care needs, as traditional medicine is often more affordable and accessible for Malagasy, especially in rural areas. But traditional medicine has also been subject to de-valorization and de-legitimization by Western influence and latent racism, creating more health care access problems that may, for the aforementioned reasons, disproportionately affect *mainty*.

Western De-valorization of Traditional Medicine

Western influence has played a major role in the de-valorization of traditional medicine through its introduction of Western allopathic medicine to Madagascar, a system that has become the primary method of health care in the country, and through its introduction of Christianity and Christian values to the country. In 1896, European missionaries began to cunningly build schools and hospitals in Madagascar with the motive of colonization; soon after, a colonial pact was formed between Madagascar and France that allowed the exportation of natural materials from Madagascar to France, who then processed the materials and sold them back to Madagascar at higher prices (Rabarijaona, 2011). To make things seem equal, France offered the provision of arms, finances, humanitarian aid, technical assistance, and political decision-making along with the creation of allopathic medical schools for the Malagasy (Rabarijaona, 2011). However,

France meant for these medical schools to replace traditional medicine in Madagascar, an intention that would ultimately contribute to traditional medicine's de-valorization in the country (Rabarijaona, 2011). As hospitals began to become established, the status of traditional healers simultaneously declined, and many retreated to rural areas in order to continue their practice (Rabarijaona, 2011). At the same time, medicinal trees and biodiversity used by traditional practitioners were burned and destroyed to make room for crops owned by France for exportation, and other areas rich in biodiversity became protected sites and parks, removing traditional healers' access from their resources and further de-valorizing their practice (Rabarijaona, 2011).

Simultaneously, the introduction of Christianity contributed to the de-valorization of traditional medicine through both its teaching that healing was not coming from nature but from God's response to prayers, and that traditional medicine was inherently evil and anti-Christian; members of the FJKM Protestant Church even took it upon themselves to burn places where traditional medicine was practiced (Rabarijaona, 2011); (Solo, 2011).

Continuing Problems for Traditional Medicine

While traditional medicine has been revived through the re-valorization of tradition and culture in Madagascar along with the creation of the Ministry of Culture and Traditional Arts, some of these anti-traditional medicine sentiments continue to linger, rooted in persistent Western and Christian values (Rabarijaona, 2011). Indeed, my own Tana family, who are deeply religious and identify as Protestant, expressed shock at the fact that our program was researching and meeting with traditional practitioners. When I told my family that we would be visiting traditional healers who practiced *tromba*, practitioners who deal with illness through possession,

my homestay sister asked with some horror if they were going to practice on us, and when I said no, she answered, “Good.” She referred to what they did as “ody gasy,” a term implying their medicinal practices as evil (Solo, 2011). However, when she saw that we would be visiting Homeopharma, she proceeded to show me an array of her own pills and remedies from that company, confiding in me, “These are actually good. And legal.” Additionally, my Tana homestay family was always excited and eager to view pictures and hear stories about traditional practitioners we visited, and often laughed at or joked about the experiences I relayed to them. Another SIT student confided that when she spoke about traditional practitioners and their identification as Christian to her own family members, her family reacted with anger, insisting, “Those people are not Christian.” Such reactions imply a disdain for traditional medicine and a disbelief that their practices are at all legitimate in contrast to allopathic medicine, reflecting the de-valorization bred by both the introduction of Western medicine and Western Christianity to the country.

Such a de-valorization and disdain can work hand in hand with latent racism when the majority of people who regularly use traditional medicine are poorer and are thus more likely to be *mainty*. Certainly, the illegalization of traditional medicine can only serve to harm *mainty* by removing from them access to a mode of health care that is much more accessible and affordable, forcing them to rely solely on an allopathic system that is both economics-based and *fotsy*-dominated. Even regardless of illegalization, the de-valorization or mere toleration of traditional medicine can still be harmful to *mainty* as it does not seek to conserve and celebrate traditional medicine, its practitioners, or the practitioners’ resources. Such an attitude can lead to less people willing to practice traditional medicine because of its de-valorization and stigmatization. As for existing practitioners, this mere toleration can still harm their practice by placing preservation of

biodiversity, or healers' resources, over conservation of this biodiversity with an allowance of reasonable access for traditional healers. Should traditional medicine be both celebrated and valorized again, their practice and need to access biodiversity would be respected, resulting in wider health care access for their communities and perhaps more people willing to become practitioners. Integrated health care might ultimately benefit *mainty* by seeking to provide communities with access to accessible and affordable care; furthermore, its valorization of traditional medicine might help to increase *mainty*'s willingness to access care because of its propensity to be culturally comprehensive, celebrating Madagascar's socio-cultural history. As the health care system currently exists, however, traditional medicine is still faced with lingering stigmatization and de-valorization due to Western influence, existing as an alternative and leaving allopathic medicine to function as the primary system of care, and ultimately contributing to *mainty*'s disproportionate lack of access to care.

Methodology

In order to compile information for this paper, I accessed a range of resources and used a number of methods in my research. Much of my factual information regarding the history of slavery, latent racism, health care, traditional medicine, and Western (particularly French) influence has come directly from class lecturers and excursion guides. Because these lecturers and guides are professionals and scholars who have rigorously studied and worked in their fields of choice, I believe the information I gathered to be reliable and trustworthy, although there is a possibility that my own biases and interpretations of this information could skew results. Other factual information regarding the aforementioned topics has come from books and scholarly articles, information which I consider dependable for the same reasons.

Some information regarding Western influence (i.e. TV, ads, and beauty products) was

taken directly from my own observations—while I trust them because I saw them myself, it is possible I could misinterpret some of these factors because of my own biases in regards to searching for examples of latent racism. Other examples of Western influence and latent racism were taken directly from interviews and conversations with my own homestay family or with other students' conversations with their homestay families. For the former example, I trust my observations to be true because I heard them myself, and I believe both sources to be particularly insightful because they offer an insider Malagasy view of race relations. However, it is possible the information could be altered by my own biases—failing that, while interesting, the views of one or two highlander families cannot account for the views of all highlander families. In addition, because my information from other families is coming from other students' observations and not my own, it is possible that those results could be less reliable.

Conclusion

Despite Madagascar's eagerness to separate themselves from their Western-French, colonized past, history and current Western influence continues to permeate and directly impact Malagasy lives. A valorization of fair skin, created by both the slave trade and by the French's preferential treatment of highlanders, has resulted in a thriving latent racism against *mainty* by *fotsy* as well as against rural residents by highlanders. This racism continues to be reinforced by persistent Western influence and strained race relations, resulting in an economic divide that leaves *mainty* socially subordinated and less economically privileged than their *fotsy* counterparts, a lack of privilege that ultimately impacts their health. The introduction of Western allopathic medicine to Madagascar has reinforced an economics-based health care system that can be said to disproportionately affect *mainty* negatively because of their economically underprivileged status. This inability to afford health care services, coupled with a lack of

hospitals and allopathic services in rural areas, can be seen as leading more *mainty* to resort to more accessible and affordable traditional medicine. But traditional medicine, too, has been a victim of Western influence, facing de-valorization, illegalization, and demonization through Western promotion of allopathic medicine and Christian values. Such a de-valorization can negatively impact *mainty* by denying or limiting their access to a much more affordable and accessible system of care, especially for *mainty*-dominated rural areas that lack allopathic care centers, services, and highlander doctors willing to practice outside of their regions. While traditional medicine is now tolerated, its continuing de-valorization and prevailing image as an alternative can continue to negatively affect *mainty* due to the country's failure to fully integrate and celebrate traditional medicine and its practitioners. The effects are clear: *mainty* are subject to a lesser quality of life and to a lower quality of health in Madagascar. While the abolition of latent racism would be an ideal situation, future research on the benefits of an integrated health care system to benefit all (especially a disadvantaged *mainty*), continued attempts at re-valorization of traditional medicine and practices in Madagascar, and interventions designed to improve rural access to affordable health care may make some headway in closing the health quality gap between *mainty* and their *fotsy* peers.

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