

THE HUT-HOSPITAL AS PROJECT AND AS PRACTICE

Mimeses, Alterities, and Colonial Hierarchies

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Abstract: This article analyzes one kind of colonial equipment designed in the early twentieth century for the purpose of providing medical assistance to the indigenous populations of Angola and Mozambique. I will refer to it as a 'hut-hospital', although it had several forms and designations. The layout of hut-hospitals consisted of a main building and a number of hut-like units that were supposedly more attractive to the indigenous population and therefore more efficient than the large, rectangular buildings of the main colonial hospitals. Using different sources, including three-dimensional plaster models of hut-hospitals, photographs, legal documents, and 1920s conference papers and articles, I will investigate the relatively obscure history of this colonial artifact while exploring the use of imitation as part of the repertoire of colonial governance.

Keywords: Angola, colonial architecture, colonialism, hospital, medicine, mimesis, Mozambique

Subject to philosophical reflection since at least the time of Plato and Aristotle, imitation was ultimately theorized by French sociologist Gabriel Tarde (1890), whose *Laws of Imitation* became a standard reference in the years to follow. There were no major conceptual changes in the study of imitation in society in the following century, except for the surrealist, psychological, and psychoanalytic explorations into the realm of the sacred and its connections with violence, as epitomized in the work on the mimesis-sacrifice dyad by Roger Caillois ([1935] 1984, 1939) and René Girard (1972). Recently, critical theorist Rey Chow (2006) speculates that mimesis and sacrifice may have fallen victim to the current politics of representation. Much of the cognitive potential of these twin



concepts thus remains unexplored, suggests Chow in her review of the complex interrelations of mimesis, sacrifice, biopolitics, and the multiple hierarchies that structure human interaction—from which emerge, among others, Agamben’s (1998) understanding of ‘bare life’ and Fanon’s (1952, 1961) ‘ambivalent subjectivities’. Sacrifice and mimesis should be salvaged for the better understanding of the “formidable—and terrifying—questions of freedom, violence, moral constraints, community, and boundary-setting” (Chow 2006: 147), and, we may add, colonial domination. In order to address this further application, I will make use of the concept of mimesis and, for the moment, leave aside sacrifice with its too literal, visceral, even graphic associations with colonialism.

It is not that mimesis, or imitation, has been absent from reflections about colonialism and colonial subjectivities. On the contrary, many works have made good use of it—from V. S. Naipaul’s (1967) *The Mimic Men* to Homi Bhabha’s (1984) *Of Mimicry and Man*; from Jean Rouch’s (1955) film *Les maîtres fous* to the scholarship that engaged with it (Lim 2002; Stoller 1992), including Paul Stoller’s (1995) explorations into the embodiment of colonial memories; from Frantz Fanon’s (1952) *Black Skin, White Masks* to Michael Taussig’s (1993) *Mimesis and Alterity* and the multiple works it inspired from different empirical and theoretical groundings (e.g., Anderson 2002; Ferguson 2002; Huggan 1997). These works sift through the connections between colonialism and imitation, be it as the incomplete, faux-copy mode of masquerade, or in the playful, ironic, and resistance-loaded mode of mimicry—to use the insightful distinction of Fuss (1994)—or yet, to use Huggan’s (1997) distinction, as the mischievous imitation that stands as mimicry, or as the mediation between different worlds that stands as mimesis.

Diverse as they are, those authors are consistent in exploring colonial imitation as almost exclusively enacted by the colonized subjects: the copy emerges from below, while the original stands on the dominating side of the colonial or post-colonial asymmetrical dyads. A similar framework is used for the exploration of contemporary cultural issues involving imitation, as in Rosemary Coombe’s (1996) discussion of patents and borders or Jean Langford’s (1999) approach to composite medical practices in India.

To this day, less has been written about mimicking from above (see Ladwig and Roque, this volume; Roque 2014, 2015a). There is only a little interrogation of situations in which the colonizers imitate the colonized subjects, and these are concerned with turning native, as depicted in variations of the embarrassing category of *kaffrealization* (Africanization), or in the romanticized freedom of Paul Gaugin in the southern seas, or again in the Orientalist enchantment of Europeans who adopted Eastern philosophies and lifestyles.¹ Finally, some authors have developed idiosyncratic theories about porous modes of colonialism based on cases in which colonial powers borrowed native themes and motives as a way to legitimate domination.²

This article focuses on a particular mode of colonial ‘imitation from above’, as epitomized by the hut-hospital. Created between the 1920s and the 1950s for the purpose of providing medical assistance to the indigenous populations of Angola, Mozambique, and other Portuguese-administered African regions, hut-hospitals were designed as fenced compounds with a main building and a variable number of smaller, hut-like constructions. The sponsors of the project believed that this was an affordable and locally sensitive type of construction and that it had the potential to attract the local populations in ways that conventional European hospitals would not. Africans tended to avoid European medicine on most occasions. If the colonial medical facilities looked more African, the planners thought, people would be less reluctant to go there.

Behind this rationale was the assumption that visual similarity had the power to erase differences and reduce distances, whether physical, social, cultural, or political. Imitation was adopted for the mitigation of dissension, as a process of ‘de-othering’ the neighbor, the enemy, the colonial subject, and, in this case, as a masquerade of one’s own self in order to please, attract, and capture someone else. The huts in the hospitals would have the power, or at least the potential, to minimize the Otherness and potential hostility of the hospital as perceived by Africans. Or at least that was what the planners thought.

I will approach the hut-hospital as a materialization of mimesis that became a technique of colonial governance. Rather than evidence of an imagined cultural propensity toward blending in, as later theorized for other aspects of material culture by Lusotropicalist authors (Freyre 1961), imitation and borrowing instanced de-othering as an exercise of power in the governance of life, or, in other words, as a technique of colonial biopower. My analysis of the ways in which colonial rulers imitated, simulated, and borrowed aspects of the indigenous cultures they ruled follows trends shared by Roque (2010, 2014, 2015b, this volume) for East Timor, Ladwig (this volume) and Tappe (this volume) for Laos, Bastos (2011, 2014) for Angola and Mozambique, Saraiva (2014) for Angola, and Xavier (2014) and Chakravarti (2014) for Goa.

The Huts in the Hospital

Evoking the trope of imitation (or mimesis) as a means to overcome (or camouflage) difference (or alterity), hut-hospitals were developed as a tool for colonial politics. Given the scarcity of analytical and primary sources on the topic, one may ask whether they were a programmatic procedure, identifiable as a mark of a certain type of colonial governance, or just an idiosyncratic project that existed in potential but was never effectively implemented in the field.

Evidence about hut-hospitals and their role in the larger spectrum of Portuguese colonial health policies is elusive. Data are scattered through rare

primary sources, defying the efforts of researchers on the topic (Bastos 2007, 2012, 2014; Coghe 2014, 2015; Duarte and Dória 2014; Duarte et al. 2012; Havik 2013, 2014; Milheiro et al. 2013). Much is still to be known about these structures: how many of them were actually built, both when and where; how long did they last; what was their impact; how were they perceived by the population and by the patients, health workers, and administrators; what was their place and role in colonial policies; what critical interpretations of colonialism can they substantiate.

Recent academic works on Portuguese colonial architecture (Fernandes 2009; Ferreira 2006; Fonte 2007; Milheiro 2012a, 2012b; Tostões and Gonçalves 2009) report extensively and in detail on the construction of large and iconic buildings, including hospitals, in Angola, Mozambique, and other colonial sites. The authors develop interesting arguments about modernism, brutalism, and tropicalism, yet they rarely mention the existence of the typology of hut-hospitals and infirmaries. In a 2013 exhibit on Portuguese colonial architecture held in a major venue in Lisbon, there was a discrete appearance of the hut structures as *sanzala* (native headquarters) in one of the plants (Milheiro et al. 2013), with no further commentary.

Approaches to ascertaining the actual existence of hut-hospitals can be frustrating: little is left of them on the sites where they were once erected, and written or oral sources are scarce. There is no complete survey about how many of them were made, where exactly they were located, and what happened to them. My own excursions to find ruins or remains in Angola and Mozambique had limited results (Bastos 2014).

However, as the study of Portuguese colonial architecture is moving from an exclusive focus on monumental works to forms that are vernacular, hybrid, and less monumental, recent findings provide good support for our quest. Meticulous research conducted by João Couto Duarte shows that some of those structures still exist, although they are hard to identify in the field as they were often subject to adaptation (Duarte and Dória 2014; Duarte et al. 2012). The exhaustive research on Angolan colonial medical sources conducted by Samuël Coghe (2014) reveals that there may have been a large number of these structures in the 1920s, but little trace is left of them now (Coghe, pers. comm.).

As for documentary sources, they include the few legal documents that mention hut-hospitals and infirmaries (e.g., *Diário do Governo*, 6 February 1944, 21 February 1945), occasional booklets published for international colonial exhibits (such as *Portugal-Colonie de Moçambique-L'Assistance Médicale*, prepared in 1931), and above all the medical articles about indigenous outreach health care presented at a pioneering international conference on colonial medicine held in Luanda in the 1920s (Blanchard 1923; Correia 1923; Sant'Anna 1923; Santos 1923).³ From these sources we can gather formal, idealized descriptions of the structure and functions of the hospitals in question,

some visual sketches of them, and a few rare photographs, as analyzed further in this article. So far, no field photography of people actively using these hospitals has been identified, nor have real-life narrative accounts of the hospitals' services.

While direct testimonies about lived experience in these compounds have yet to be found, evocative objects and documents related to their conception and implementation will provide the empirical basis for the discussion in this article. Among those objects there is a collection of three-dimensional plaster models representing different health care constructions (Duarte et al. 2012). After some years inhabiting obscure locations, the collection is currently on exhibit to the public in the top hall of the Tropical Medicine Institute in Lisbon (Duarte and Dória 2014). These objects will, for the moment, move to the center of our analysis.

The Social Lives of Plaster Models

The three-dimensional plaster models representing hut-hospitals will hold the spotlight in this section of the article. They will be addressed along the lines suggested by anthropologists engaged in the study of objects as sources for understanding social relations and wider politics (e.g., Appadurai 1986; Kopytoff 1986; Miller 2008; Porto 2007, 2009). What was the history and social life of these plaster models? What does their 'biography of objects' tell us about the uses of imitation in colonial policies and about colonialism in general? The next paragraphs will be dedicated to exploring further the biographies of these second-degree objects of imitation. I will discuss what they are, when they were made, as well as why, where, and by whom, and their afterlife since being manufactured.

What

When we think about these models as architectural maquettes that for some reason outlived the stone-and-concrete life-size buildings they heralded, a tone of dissonance emerges from the fact that the fragile plaster models have survived to the present day so remarkably clean and well-finished while the constructions they ought to have inspired are very hard to find. The dissonance dissipates when we get to know a little more about their object biographies. Rather than anticipatory models, they were modeled after constructions that already existed, even if embellished or made to look more regular and geometrical than they might have been in the field. The intent behind their production was to showcase the constructions of the Gabinete de Urbanização Colonial (Office of Colonial Urbanization) (Duarte and Dória 2014; Duarte et al. 2012).

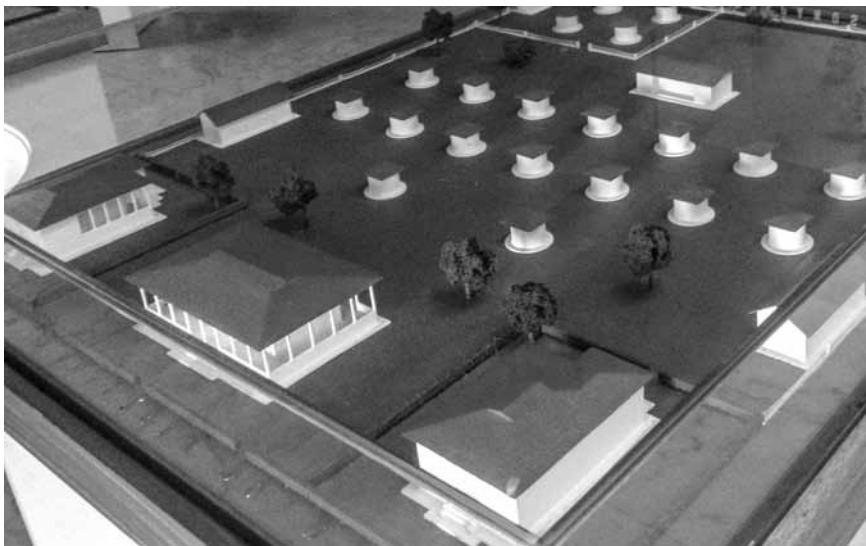


FIGURE 1: Maquette of a health center in southern Mozambique. Collection of the Institute of Hygiene and Tropical Medicine, Lisbon, Portugal. Photograph © Cristiana Bastos, 2014

When

Thanks to recent research (Duarte and Dória 2014; Duarte et al. 2012), we now know that those models were produced for an exhibition that took place in Lisbon in 1952: the “Exposição Documental das Actividades Sanitárias do Ultramar” (Documentary Exhibition of Overseas Health Activities). The exhibit coincided with the jubilee of the Tropical Medicine Institute and the Colonial Hospital, both founded in 1902 and later renamed the Overseas Hospital (Hospital do Ultramar). This was a moment when Portugal drifted away from what was becoming the shared trend for European imperial powers after World War II. While most prepared for decolonization and anticipated new modalities of engagement with the emerging Asian and African countries that replaced former colonies, the Portuguese government invested like never before in the colonial project in Africa (Castelo 2007). A whole new vocabulary for colonial governance was put forward. What had once been the colonies were now the overseas provinces. What had formerly been the empire was now a transcontinental, multi-local imagined community of organic Portuguese, theatrically exhibited in two previous major fairs in 1934 in Porto and 1940 in Lisbon as “O Mundo Português” (The Portuguese World) (Serén 2001; Thomaz 2002). What had previously been relatively disjointed colonial policies, left to the agency and judgment of those in the field, were now a priority for the central government (Alexandre and Dias 1998; Castelo 2007).

Why

At that juncture, narratives had to be brought together to support the claims of the originality, value, and goodness of the ‘humanitarian civilization’ that in the Portuguese official vocabulary replaced empire. Stories, tales, images, symbols, and objects that could be displayed as evidence of a long-term engagement of the Portuguese with overseas peoples were now used for showcasing the reinvented empire. At that exact moment, Gilberto Freyre had been invited by the Ministry of the Colonies to go to different places in Africa and Asia under Portuguese administration, to take notes, and to write about the unique Portuguese mode of benign colonization. Freyre (1953) would later come up with the theory of Lusotropicalism (see also Bastos 1998; Castelo 1999). But the term had not yet been coined at the time of the exhibit. Nor was there a complete transition from an ideology of imperial glory and conquest to the later claims of humanitarian, interactive civilization in the tropics. Both in law and in life, the colonial regime in Portuguese Africa in the early 1950s was about separation and segregation, with ideologies of white supremacy and economies based on indigenous labor. In a sense, the inclusion of models of segregated infirmaries—of hut-hospitals that looked so clearly like native headquarters—fulfilled the purpose of promoting medical care for all, while making it look different for different groups.

Where

The 1952 “Exposição Documental das Actividades Sanitárias do Ultramar” was held in the Burnay Palace, Rua da Junqueira. The plaster models of hut-hospitals were part of a larger set of models representing health buildings in the colonies, from smaller infirmaries with half a dozen huts to large-scale, monumental central hospitals, to the Tropical Medicine Institute, which was soon to move into the large modernist headquarters it now inhabits, also in Rua da Junqueira. From the catalogue and the pictures, we can see that the exhibit was a grand and solemn event. While the previous exhibits of 1934 and 1940 had been massive occasions that attracted thousands of people (Serén 2001; Thomaz 2002), this was a selective showcase, prepared for the eyes of health professionals and politicians. Together with the models, there were plenty of tables and images reporting on medical missions in Africa. There was one room for the Tropical Medicine Institute, one for the Colonial/Overseas Hospital, two for Angola, one for Mozambique, one for Guinea, Cape Verde, and São Tomé and another for India (Goa-Daman-Diu), Macao, and Timor, plus one for tropical plants and yet another for corporations in Angola, with a highlight on Diamang. It was predominantly in the room dedicated to Mozambique that the hut-hospital models were shown.



FIGURE 2: Aspect of the overseas health activities exhibit, Burnay Palace, Rua da Junqueira, 1952. Collection of the Institute of Hygiene and Tropical Medicine, Museum Photographic Album IHMT.000535, photograph # 35, permission kindly granted by the Institute of Hygiene and Tropical Medicine, Lisbon, Portugal

By Whom

A study of the documents related to the exhibition, including letters, memos, and references to shipments of boxes and packages, along with other elements, enabled authors João Couto Duarte and José Luís Dória (2014: 4, 29–30) to establish that the models were made in Mozambique from 1951 to 1952 and shipped to Portugal in the vessel *Quanza* for the purpose of being exhibited during the Tropical Medicine Conference, itself scheduled to coincide with the jubilees of the Tropical Medicine Institute and the Colonial/Overseas Hospital. Although there is no official record of the artists who produced the models, they took the initiative of inscribing their signatures and playful comments on the bottom of one of the box cases—the one that supports the model of the Marraquene maternity facility. The text reads: “These maquettes and all of the graphs were made by the competent worker-artists.” The signatures read: “Master-general João Aires, picasso artist” “Francisco Matos Lopes, Horácio Alves dos Santos Portugal, Joaquim Portugal dos Santos, all great guys.” Individual signatures of “João Aires, competent painting artist,” “Serafim Rebelo, officer on duty,” “Francisco Matos Lopes, carpenter,” “Horácio Alves dos Santos Portugal,” “Joaquim Portugal Santos,” “Seturate-painter,” and “Ramalho-painter” complete the entangled inscriptions transcribed by Duarte and Dória (ibid.: 29).

Afterlife

Once the exhibit was over, the plaster models turned into something other than what they had been commissioned for. Their existence became detached from the web of intentions and agencies that had brought them into being. They lost their original meaning and achieved new ones. No longer objects of public visibility, they were now ‘has-beens’ with no assigned role or place—too good to discard and trash, yet not valued enough to be worth the cost of shipping them back or keeping them visible. They remained in Lisbon, semi-abandoned in warehouses (Duarte and Dória 2014: 5) until they were rescued from further decay by artist and restorer Luis Marto from the Tropical Medicine Institute (*ibid.*: 7). Throughout the 1990s and early 2000s, the models occupied different places in the corridors and back alleys of that Institute, eventually to be fully restored and exhibited in great dignity in its main hall with a dedicated institutional catalogue (*ibid.*).

As suggested elsewhere, the travels of those objects between the gray areas of shade and the lights of the exhibit hall go hand in hand with a shift in attitude of the Tropical Medicine Institute about its colonial past (Bastos 2014). The Institute was originally fashioned as a central pin in a system of medical research and assistance related to the colonies. After the 1975 period of decolonization and the birth of new African nations, it maintained ties with the same places in Africa, now providing assistance in development. References to past colonial ties were suspended from systematic reflection for a few decades, and the relationship to the material objects related to that past was also suspended, leaving the collections in oblivion. Recently, they have received new attention as objects of heritage and are now the subject of prestigious exhibits.

Imitation Exponential: Models That Mimic Mimetic Hospitals

If the miniature hospital models may be depicted as a product of mimicry, a conscious exercise of imitation (not without the playful component of the artists’ hidden inscriptions), they also work as multipliers of imitation procedures, as they endeavor to replicate—for purposes of a celebratory exhibition—what had started as an imitation, or mimesis, in a colonial setting. The models aimed to show how hospitals sought to duplicate indigenous housing. It is now time to investigate the projects and programs that generated these hospitals and the actual practices to which they corresponded.

The most comprehensive description of the hut-hospital as a project was presented at the 1923 Tropical Medicine Conference held in Luanda. The conference was a scientific landmark, hardly ever replicated. It was graced by the presence of various international medical celebrities of the time and was organized thanks

in large part to the efforts of António Damas Mora, whose role in Portuguese Tropical Medicine has yet to be fully acknowledged (Coghe 2014). The proceedings were published in the coming years in the journal *Revista Médica de Angola*, which was created for that purpose. They include a complete transcription of the papers presented in the sessions, of the discussions that followed, and of the complete articles written by the authors. Several of them discuss modes of better promoting health outreach for the indigenous populations (Blanchard 1923; Correia 1923; Sant'Anna 1923; Santos 1923). Their commitment to the mission of keeping more people alive and healthy in places of empire reveals that the colonial biopolitics of that moment corresponded to a mandate for life in the classical Foucauldian sense, but also that this same mandate rested upon an understanding of difference, separation, and hierarchization of groups.

It is worth noting that there was no consensus at this conference on what were the most efficient ways of promoting the health of indigenous groups. While Ferreira dos Santos and others were committed to the creation of special hospitals, or infirmaries, in the rural outpost serving indigenous populations, with constructions “like the common huts, with conical roof, a little higher, with a glass window and a door … and a cemented floor” (transcript of the second session, 17 July 1923, 12), not everyone in the audience agreed on the fact that different construction types should be made for different groups. Dr. Santos Jr., for example, commented that providing medical assistance to the indigenous populations should be “just like providing assistance to the white people, forgetting color, not separating the white patient and the black patient” (transcript of the second session, 17 July 1923, 24). But the idea of making constructions that mimicked indigenous housing was the most prominent of the day.

J. Firmino Sant'Anna, a prominent professor of Tropical Medicine in Lisbon who had much experience serving in the colonies, provided an extensive memorandum about every possible dimension of assistance to the African indigenous populations, including how to compromise with African practices while still providing good care (e.g., the doctors should act like African healers and minister the prescribed drugs to themselves), how to select locally sensitive approaches, and why not to insist on prescribing things that might be incompatible with local traditions (e.g., baby bottles). When it came to the hospitalization systems, Sant'Anna (1923) was firm in suggesting that the races should be separated. He made clear that he did not mean to separate black from white, but to separate those who kept their traditions (*indígenas*) from those who were under the sphere of European society (*ibid.*: 153). As for the equipping of indigenous hospitals and infirmaries, he suggested that instead of multiple permanent buildings, the structures should be fewer and more transient, “whether canvas tents, pavilions, or huts in the *kaffreal* style, or portable rooms, etc.” (*ibid.*: 154).⁵

The most articulate arguments supporting hut-hospitals came from Ferreira dos Santos (1923: 65–69), who conceived a complex system with major health

centers and a full hierarchy of larger and smaller outposts. He argued that the hut-like constructions would cost less, would be easier to maintain, and, above all, would be more attractive to the indigenous populations, who, he claimed to know based on his own experiences, were traditionally reluctant to accept European health care (*ibid.*: 66). In other words, Santos argued for imitation as a means to reduce differences and as a device to create proximity via resemblance.

Other authors added their arguments defending the construction of separate infirmaries that looked like indigenous housing. Germano Correia, a physician from Goa who had also served in Angola and whose racialized views of the world have been analyzed previously (Bastos 2005), suggested that indigenous patients should not face abrupt transitions when receiving medical care: moving from their dark huts into bright infirmaries might make them dizzy (Correia 1923: 187). Also, the construction should have internal and external features that are able to “attract, agreeably, the attention and interest of the inpatients, through the similitude of architectonic particularities, which can remind them of the huts” (*ibid.*: 187–188). For those reasons, he supported the construction of *enfermarias sanzalas* (native-settlement infirmaries).

Regardless of what they might have thought about African imitations of Europeanness, they were pleading for European imitations of Africanness, putting this forward as a practicable and desirable tool of empire at no less a forum than a prestigious international conference on tropical medicine. And as if anticipating the colonial and post-colonial theorizations, Santos and Correia displayed a

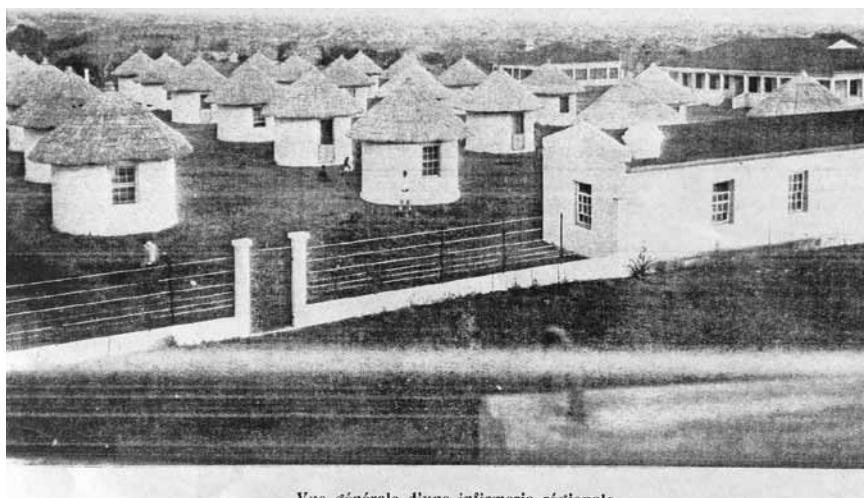


FIGURE 3: Photograph of a hut-hospital compound. Included in *Portugal-Colonie de Moçambique-L'Assistance Médicale*, a booklet prepared for the International Colonial Exhibit in France, 1931

note of further originality in an almost-but-not-quite mode. While the huts were supposed to look like those of the natives, round with straw conic roofs, they ought also to adopt all the modern materials of construction: cemented walls, pavements, doors, glass windows, and whitewash finishing.

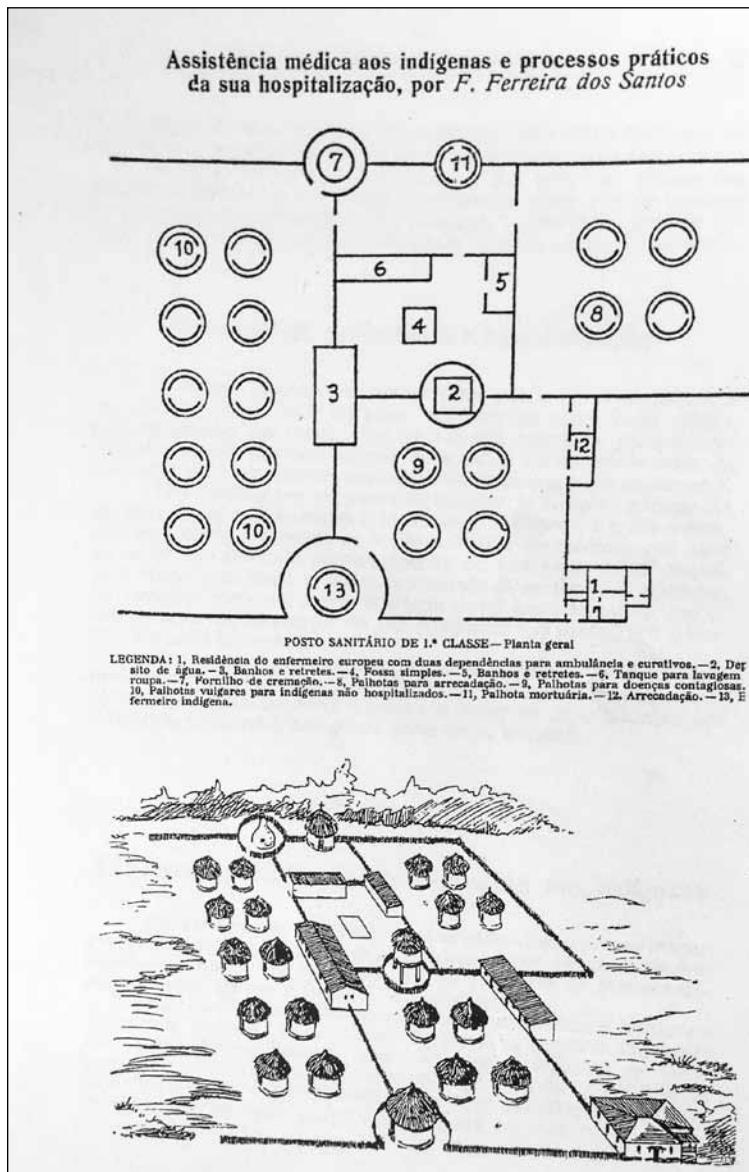


FIGURE 4: Sketch of a first-class health outpost. Included in Santos (1923)

Projects and Practices of Colonial Domination

The hut-hospitals sketched by Ferreira dos Santos (1923) seem to represent the exact same thing as those represented in the plaster models analyzed earlier in this article. Yet they stem from different moments in the long and scattered history of Portuguese colonial biopolitics. When Santos and his colleagues gathered in Luanda to discuss modes of outreach for the indigenous populations, they seemed truly to be engaged in finding better solutions to keep Africans alive and healthy. Whether the main purpose behind their efforts related to the need for cheap, docile, and abundant labor or was rooted in more humanitarian principles and the mandate to protect life—or perhaps was an equal measure of both—is a matter for further discussion, as noted by Coghe (2014) in his analysis of demographic anxieties in colonial Angola.

The 1920s were a time when there was room to explore new ideas, models, and projects. Portugal was under what came to be known later as the First Republic (1910–1926), that is, the first wave of republican, democratic governments. Aspirations to make up for lost time and to overcome the backwardness attributed to monarchic rule were now in the air. The colonies should also make up for the backwardness they were presumed to be left in, and the most modern techniques of governance should be implemented. The atmosphere would change in the coming decades, and a very long authoritarian regime was about to begin. The cosmopolitan open-mindedness of the 1920s gave way to the gloom of the 1930s, followed by a political cycle with a self-contained ideology of exceptionalism that peaked in the 1950s and 1960s and lasted until the mid-1970s.

In the transition decade of the 1930s, there was conceptual and political space for the implementation of some hut-hospitals in precise locations. There is evidence regarding support for *tabancas enfermarias* (infirmary villages) in Guinea (now the country Guinea-Bissau). The booklet *Assistência aos indígenas da Colónia da Guiné* (Imprensa Nacional da Guiné 1933) argues in favor of those compounds, which had been established, together with the Fundo de Assistência Médica Indígena, by Legal Decree #728 (dated 18 December 1932). The text noted that Africans dreaded the Portuguese system of assistance and would rather hide and die than seek out Portuguese health care. The *tabanca* thus attempted to recreate a friendly environment, made to be similar to the patients' own hamlets and allowing for the presence of relatives—while at the same time attempting to keep invalids under such a close watch that they were unable to escape (ibid.: 6). The *tabanca* was thus a mock native village, used consciously as a tool of colonial biopolitics in the more remote regions of Guinea.

At precisely this time, Portuguese politics were about to shift into what became the basis for the long-lasting regime of António Salazar. The year 1933 was also the year of legitimization for the Estado Novo or New State (the Second Republic) and for the Colonial Act, which separated the population into two

groups: whites and *assimilados*, on the one hand, versus natives (*indígenas*), on the other.⁶ In the 1940s, a wave of legislation regulated the colonial health services. The Gabinete de Urbanização Colonial (GUC) was created in 1944 with the purpose of improving the quality of construction in the African colonies (Legal Decree #34173, 6 December 1944). It was inspired by an exhibit held at the engineering institute in Lisbon that promoted cooperation between engineers and architects. From then on, African hospitals, like other constructions, were to be supervised by the GUC.

In 1945, a complete program for the colonial health services was defined in the extensive Legal Decree #34417 (21 February), which marked the biopolitical agenda for the coming decades. The purpose of the program was to “support, defend, and expand the indigenous population” (the labor providers) and also to help white settlers adjust to the tropical regions. The program provided for the creation of a central hospital for each colony, plus regional hospitals and health outposts in varying numbers. It explicitly promoted a veiled apartheid, segregating the health care facilities made for whites and ‘assimilated natives’ from those made for the ‘non-assimilated natives’. The principles stated by Ferreira dos Santos 20 years earlier were now adopted as a programmatic law:

In the colonial hospitals it is required to separate the headquarters for Europeans and *assimilados* from those destined to the natives (*indígenas*). Not because of racial prejudice (as shown by the fact that assimilated natives have a place together with Europeans), but to accommodate the differences in mentality and habits. The indigenous peoples only feel at ease, even morally comforted, when they do not miss the atmosphere they are used to. Is it better, or worse than ours? If it ought to be changed, that will be a matter of slow persuasion and adaptation; not by the imposition in exceptional periods of life.

For that reason it is admissible that on certain occasions the indigenous person can live, not in an infirmary, but within the circumscription of the hospital, in an independent home, part of a village, eventually accompanied by the family, that came along from afar. The housing should be built in the indigenous style, however improved in the use of materials, capacity, orientation, protection against solar rays, comfort, and hygiene, etc., so that they provide a model for their own evolution. (*Diário de Governo* 21 February 1945: 96–97)

The hut-hospital was thus adopted not just as a means to attract more of the indigenous population into the hospital, but also as an educational device. The ‘almost’ in its ‘not-quite’ mode—looking African, but made of supposedly more advanced construction materials—worked as an asset in the promotion of a taste for what Europeans considered better housing. Efforts to attract the local population into the hospital were expanded and included the possibility of setting up entire villages around the health compounds, so that some

patients could be lodged in the vicinity while receiving medical care as outpatients (*Diário de Governo* 21/2/1945: 103).

Almost-but-Not-Quite: Partial Imitation as a Colonial Tool

In this article I have presented a case of imitation as a colonial device: the conception, the practice, and later the programmatic adoption of hospitals with hut-like housing as a means to attract indigenous populations into colonial health care. I have addressed the hospitals as imitations and the plaster models of the hospitals as second-degree imitations. At once unusual yet familiar to their targeted African patients, the models embody the colonial program, configure colonial and para-colonial encounters, and evoke missions to rural colonies and settlements. They contain within them the tensions of colonialism, in its hybridisms, pastiche, collage—the private tensions of a particular utopia inscribed in a device that combines the aesthetics of futurist design, on the one hand, and of a certain rural, colonial nostalgia, on the other. Like self-aware simulacra, the models seem to idealize local constructions and reinvent them by adopting original materials and using a regular, geometric layout.

A discussion on whether this sort of imitation and its outcomes should better be considered mimesis (Taussig 1993), mimicry (Bhabha 1984), mockery, masquerade (Fuss 1994), pantomime, or simulacra (Baudillard 1981) would in my view be a relatively sterile exercise in the academic vertigo of shifting signification and representation politics (e.g., Chow 2006; Trajano Filho 2011). I find it more productive to analyze the ways in which colonial powers have used imitation as a means to simulate the erasure of distance under an agenda of domination, while creating enhanced possibilities of fashioning their narratives of collective selves, along the lines suggested in the studies of imperial tensions (Bastos et al. 2002; Cooper and Stoler 1997; Stoler 1995, 2002).

In the case examined in this article, imitation took the ‘not-quite’ mode of looking indigenous while using modern European sanitary devices. From the beginning, this was an appealing display of colonial apparatus: sympathetic, via imitation, but ‘not-quite’. And while in the 1920s the rationale behind the display of similitudes might have been guided by humanistic principles of life promotion, when the seed project gave way to a programmatic law, it became clear that the almost-but-not-quite mode now corresponded to a regime of segregation, veiled apartheid, and a masquerade of inclusiveness that would have its higher ideological formation in the myths of Lusotropicalism (Freyre 1953, 1961). In other words, the imitation analyzed in this article appears to be less about inclusiveness than about keeping clear and visible the principle that each individual and type must be assigned one specific place in a divided, hierarchical, and racialized order.

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Notes

1. The enchantment and awe with Eastern philosophies, a form of Orientalism in the broad sense, differs from what is theorized by Said (1978) and is closer to Vicente's (2012) depiction in *Other Orientalisms*. It corresponds to the use of imitation by eighteenth- and nineteenth-century European men and women who experienced existential transformations in places like Turkey, Egypt, or India and merged with those cultures by borrowing the local looks and customs.
2. Although borrowing local elements occurred frequently in many places and times, no author argued so consistently on the matter as Brazilian sociologist-anthropologist Gilberto Freyre (1952, 1961). Freyre claimed that the Portuguese colonizers had a special vocation to mix, mingle, and adopt the ways of the natives they encountered throughout the world, thus creating what he described as an original form of civilization—Lusotropicalism. Regardless of the value of Freyre's occasional insights about historical details, his theories have been dismissed as ideologically loaded. Particularly after 1961 they were conveniently useful to, and used by, the dictatorial regimes of António Salazar and Marcelo Caetano in Portugal (roughly from 1933 to 1974), as they provided a doctrine and pseudo-theoretical basis for a supposedly more benign, supposedly less racist, long-lasting colonial regime in Africa. See Bastos (1998), Bastos et al. (2002), Castelo (1999), and Castelo and Cardão (2015), among others.
3. For further analyses of these articles on indigenous outreach health care, see Bastos (2014) and Coghe (2014).
4. Unless otherwise indicated, all translations are my own.
5. *Assimilados* were Africans who adopted European lifestyles, including language, religion, clothing, housing, diet, and so forth. Their status allowed for some rights of citizenship that were denied to *indígenas*, who were subject to harsh labor demands.
6. The sources about this exhibit are very scarce. I thank architect João Couto Duarte and my colleague Jorge Freitas Branco for their assistance on the topic.

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