2011 marks the beginning of a UN Decade of Action for Road Safety. Its scope is ambitious: to save five million lives and prevent 50 million injuries by the end of the ‘decade’ in 2020. According to statistics published and defended by the World Health Organization (WHO), a major participant in the global road safety lobby, some 1.3 million people die every year in road crashes, with up to 20 million more disabled for life. WHO’s slogan, ‘Road safety is no accident’, represents a shift in thinking about road crashes, with an organizational turn towards public health interventions and, more specifically, a construction of the perceived problem as one of violence and injury prevention.

Framing road safety in terms of public health has led to the medicalization of the problem, with the WHO endorsing catchphrases describing road deaths and injuries as an ‘epidemic on wheels’ or a ‘disease of development’. In some instances, the preventative focus of the WHO’s interventions has called for novel ways of looking at road safety, with an organizational turn towards public health interventions and, more specifically, a construction of the perceived problem as one of violence and injury prevention.

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I am broadly interested in the cultural history of health and injury politics in ways that disempower those seeking compensation. In Africa, who had for some time noted the way recent road crashes emerged out of a ‘tolerance’ of road death and injury, an ideological position, MacLennan suggests, ‘radically different from our concern with diseases such as cancer and AIDS, which are characterized by a strong public demand for a cure’ (MacLennan 1988: 233).

This comment by an anthropologist raises several issues in relation to the distinction between ‘road safety’ in Africa – or other ‘developing nations’ worldwide – and the more recent concern with ‘automotive safety’ in the USA and other vehicle manufacturing nations. The key lies in the notion of a ‘cure’, and where the focus is thought about. The global road safety lobby is not principally concerned with questioning the deep assumptions of automobility, but rather with extending it as an ideology and making automotive transport a necessity of everyday practice well into the future.

In the USA, ‘automotive safety’ has emerged out of a long and protracted struggle between consumer activists, scientists, government agencies and the automotive industries over questions of design and tort law (Jain 2004). It focuses on the harm that car, lorry and motorcycle design can do to the soft machine of the human body. ‘Road safety’, in Africa, begins from the assumption that automobility is not a problem – in fact, it can be a solution to many problems of development – but that road users are. The larger context of road safety in Africa incorporates concerns that 20 years ago were subsumed under the category ‘good governance’, exemplified by campaigns to stop the ‘radicate’ corruption. Road safety in Africa is not about automobility to the same extent as ‘automobile safety’ is in the USA, but rather about fixing a decrepit road infrastructure, reforming insurance loopholes, delivering efficient licensing and proficient drivers, and reducing illicit practices between drivers and traffic police. That the public health idiom has come to pervade the rising focus on road safety in Africa surely raises questions about the direction this lobby is taking in different parts of the world.

A brief period of fieldwork with taxi drivers in Dar es Salaam, Tanzania, brought to the fore how road safety campaigns in eastern Africa appropriated the language of public health, arguing that road crashes were a disease, epidemiologically on par with malaria or tuberculosis. This medicalization of the public health and education component of the global road safety lobby was further illuminated through discussions with colleagues in South Africa, who had for some time noted the way recent road deaths every year, a number said to be on the rise owing to the larger volume of imported second-hand vehicles and the growing availability of consumer credit.

I first became involved in this project through witnessing road crashes, being involved in them, and through bereavement. But road safety is an urgent issue for all African countries: as I write, during South Africa’s hosting of the FIFA World Cup, a major news story breaks about the road deaths, in separate crashes, of three young British tourists and the great-granddaughter of Nelson Mandela. It need not be overstated, but these cases become news-worthy because of the highly inflated coverage of the road deaths of foreigners and celebrities in the African media. South Africa sees some ten thousand road deaths annually, casting a gargantuan shadow over these few reported cases. Africa’s ‘road carnage’, as it is often called, is in danger of being essentialized, and the ongoing tragedies almost certainly trivialized (see Roberts 2007).

Radical epidemiologists involved in road safety, from William Haddon Jr in the 1960s to Ian Roberts today, make very clear how they liken road crashes to infectious disease, seeing both as stemming from environmental causes. This is a methodological issue that public health educators fail to clarify. This move has precedent in the USA, where the shift to an epidemiological stance towards road crashes emerged out of a ‘tolerance’ of road death and injury, an ideological position, MacLennan suggests, ‘radically different from our concern with diseases such as cancer and AIDS, which are characterized by a strong public demand for a cure’ (MacLennan 1988: 233).

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safety campaigns borrowed from HIV/AIDS activism. One cited a public-service radio advertisement for buckling up that centred on a conversation where a woman urged her partner to wear a seat belt (Rebekah Lee, personal communication). This particular advertisement ended with the challenge: ‘If you love your partner, you’ll wear a seat belt.’ In the South African context there is a not-so-very subtle reference in place, where the substitution of ‘seat belt’ for ‘condom’ tells a similar story about a new subjectivity of (inter)personal responsibility in looking after one’s own health and safety amid quite threatening structural insecurity.

Personal responsibility is a hallmark of the global road safety lobby’s educational and enforcement campaigns. Targeting individual behaviour is widely viewed as the only way to reduce road fatalities and injuries. At the exclusion of structural considerations, like the poverty that forces water-cart operators and street hawkers to jostle for space with cross-continent fuel tankers and presidential convoys, personal responsibility and the notion of a rationality calculating and obedient subject run fluidly through the discourse of road safety campaigns.

In 2009 Costa Rica’s transport minister, Karla Gonzales, was presented with a prize by the ‘Make Roads Safe’ campaign – the road safety NGO that meets with the automotive industry’s approval – for her introduction of new seat-belt legislation and an extensively mediated public awareness campaign for buckling up, with the slogan ‘Por amor’ (‘For love’). The campaign logo, a cartoon heart being buckled up, signals the idea of (inter)personal responsibility for one’s own safety.

A bold theory of human agency is inflected through much of the global road safety lobby’s assumptions. The ‘Make Roads Safe’ campaign ideologically supports other campaigns that stress human error as the reason behind road crashes. Hardly ever are cheap transport costs, unsafe lorry fleets, or even the ideology of automobility itself brought into conversations about the rising rates of death and injury. Arriving at this ideological conclusion itself brought into conversations about the rising rates of death and injury. Arriving at this ideological conclusion remains the logical focus on personal responsibility, it remains the case that the majority of those killed or injured on eastern...
African roads are frequently blamed for their own deaths on the grounds of their ‘lack of knowledge’ about the danger of being on the road, as one insurer put it to me. One consequence of this ideological stance is that their deaths are trivialized and the circumstances surrounding injuries depoliticized.

**One in a million**

October 2007, rural Kenya. The construction of an asphalt road commissioned by the Ministry of Roads and Public Works, under contract to the large engineering construction company H. Young, was a long anticipated development championed by the people of Mikinduri. For years, the only repairs made to their road networks had been conducted by British American Tobacco, road works that inevitably drew on cheap, unskilled local labour and whose façade of durability barely lasted one seasonal cycle from drought to deluge. Cut off from the region’s markets twice a year by heavy rains that washed out bridges and turned tracks into impassable bogs, the dream of a 52-kilometre sealed road linking them to Maua and Mutindwa, the region’s largest towns, was fast becoming a reality the last time I visited this favourite of my former field sites.

The project cost SUS 27.3 million and took 18 months to complete, transforming the hilly landscape and the time it took to traverse it. When I was last there, huge loaders and excavators trundled about, shaking the sun-baked earth and kicking up plumes of dust seen from miles around. The still unfinished road became a staple topic of conversation. *Khat* and maize farmers alike spoke with relief about market accessibility. Teachers expressed enthusiasm that they could travel to administrative centres quickly and easily. And Mikinduri’s three bus operators noted with confidence how much cash they would save on maintenance, with parts lasting longer.

People were excited when they spoke of a planned roundabout at the main junction: something urban in a trading town that only received electricity a decade ago. But others were also worried about the children who, they argued, were conditioned to the slow pace of vehicles on the dirt road and would not appreciate the dangers of cars and vans moving at high speeds along the tarmac. And so, predictably, it came to pass that a child died.

She was about seven or eight years old. Sent by her mother to buy cigarettes for a house guest, this little girl was run over by one of the H. Young dump trucks and crushed. Contrary to what might be expected of an ethnocentric morality, she was not the fatality that concerned me, but the incident, much of it reserved for the girl’s mother, a local banker. She is a robust, healthy and hard-working mother of four, she is a blind and paraplegic 44-year-old woman called Wanjiku (a common enough name used to signify any adult working-class or peasant woman in Kenya) evokes not so much pity as it does a kind of frank caricature of Kenyan inequality. Such stories, like ones about people with AIDS, fill a niche in the Kenyan imagination. Bereft of livelihood and limb, Wanjiku cannot feed or wash herself. Previously a robust and hard-working mother of four, she is now abandoned and forgotten. A neighbour’s small child comes to bring her bits of food and water. If and when the courts decide upon her claim for compensation, she cries, her children will come back for the money, but not for her.

Lying in the dark of her timber and corrugated tin-roofed house, the question of compensation is ontologically fused with her lingering, painful disability. It is no longer a question for doctors and nurses, but for insurers and lawyers.

We need to pause and ask whether road deaths and injuries can be reduced to disease and illness, as some epidemiologists have asserted. If the little girl died from malaria, would the circumstances and implications of her death be the same? If the wounded woman permanently isolated in her house were dying of advanced AIDS, would her death not be subjected to different moral dispositions and legal consequences? I ask these questions because I think that the conflation of road death and injuries with disease theoretically undermines what Paul Farmer, in his engaged work, has been emphasizing: that injuries are not just an accident of history but a product of structural dispossession.

As injury epidemiologists, public health educators and insurers increasingly eschew the Aristotelian notion of ‘accidents’ as unforeseen misfortune and come to see them as ‘crashes’, with human agency to blame, the tendency to view road death and injury as an ‘epidemic on wheels’, as prominent WHO professionals have recently advocated, has unintended but highly constraining implications for what interventions can be made with the aim of reducing the number of people killed and maimed by automobiles. To borrow from James Ferguson’s (1994) ethnography of development in Lesotho, the place of public health in the global road safety lobby risks being an ‘anti-politics’ machine if forms of social differentiation, objectification and exclusion are not pragmatically accounted for.
Diseases of development

But what do such examples taken from Kenya tell us about road safety as a ‘method of hope’ (Miyazaki 2004) enmeshed with public health and its professions? The range of professionals working on road safety does raise the classic problem of people talking past one another, and if we take Miyazaki’s understanding of hope as a ‘method that unites different forms of knowing’ leading to a ‘radical temporal reorientation of knowledge’ (ibid.: 4-5), perhaps downplaying the political and legal ramifications of road collisions and highlighting them as an iatrogenic consequence of automotive capitalism – that is, a ‘disease of development’ – this strategy provides a focus through which the global road safety lobby can galvanize resources and act in an apparent, if not real, unison.

The diffuse metaphors of medicine, say, drug addiction as a ‘cancer’, or child neglect as a ‘plague’, can reach across different forms of knowing and suppress points of potential or real disagreement. Similarly, speaking of road death as an ‘epidemic on wheels’ simplifies what is at stake and, in a continent such as Africa, can build upon development discourse in which disease and cure legitimize (colonial) interventions (see Vaughan 1988). Indeed, the recent focus on road safety in terms of ‘curing their ills’, as Vaughan puts it, works ideologically in Africa because it has a long historical precedent of medical, and hence developmentalist, intervention.

Lest I be misunderstood, and be accused of an unwarranted attack on a worthy cause, my intention here is to demonstrate how relying on a language of public health concerning road safety in Africa plays into a historical context in which disease, illness and affliction become essentialized as something inherently African. I would argue that the same thing sadly goes for road crashes in Africa, perhaps exemplified by the Swahili proverb ‘Ajali haina kinga’ (‘accidents have no remedy’), but urge that we see these conflations as ideological reflections of a larger process of long-term transnational governance, a project that has the perhaps unanticipated effect of diminishing road crash victims’ lives and technocratic denial of the politics involved in road safety engineering, enforcement and education.

As the ‘Make Roads Safe’ campaign confidently refers to helmets and seat belts as ‘vaccines’, it operates in an ideologically interventionist context, in which the legitimation of medical interventions, past and present, goes unquestioned as an unmitigated good. What needs to be known, however, is to what degree this appeal to public health, as a form of good practice, creates situations in which injury issues, especially those of the ‘poor’, continue to be settled out of court, or not at all.

**Fig. 6 and 7.** A comparison of road traffic death trends in Kenya (above) and the United Kingdom (below). In 2007 deaths in Kenya and the UK respectively were predominantly of pedestrians (47% compared to 21%), followed by passengers in 4-wheel vehicles (33% and 19%), cyclists (9% and 4%) and riders of motorized 2- or 3-wheelers (1% and 19%). http://www.who.int/violence_injury_prevention/road_safety_status/country_profiles

**Fig. 8.** Most casualties on African roads are sustained by people standing at the roadside or pedestrians, many of whom are killed on the soft shoulders of busy roads going to and from work or home. Here, in South Africa, there is new impetus to purchase life insurance as cover against accidental death.