PARTNER TO THE POOR A Paul Farmer Reader

Edited by Haun Saussy Foreword by Tracy Kidder

CONTENTS

PART 1. ETHNOGRAPHY, HISTORY, POLITICAL ECONOMY

PART 2. ANTHROPOLOGY AMID EPIDEMICS

PART 3. STRUCTURAL VIOLENCE

PART 4. HUMAN RIGHTS AND A CRITIQUE OF MEDICAL ETHICS

This page intentionally left blank

Foreword

Seeing the Proof

Tracy Kidder

A few years back I wrote a book called *Mountains Beyond Mountains.* It has a subtitle: "The Quest of Dr. Paul Farmer, a Man Who Would Cure the World." I don't much like subtitles and I didn't add this one willingly, but I suppose it's accurate enough. My book is mostly about one person, Paul Farmer, and, as we all know, the old saw that one person can make a difference in this world really isn't the whole truth. Paul Farmer never wanted me to imagine that he alone was responsible for the early work of Partners In Health. In fact, I think that if he'd been the writer, he would have given equal time to all the people involved in the early days—to Tom White, and Jim Yong Kim, and Fritz Lafontant, and Ophelia Dahl, and Loune Viaud, and Todd McCormack, and Haun Saussy, and the rest of a cast of at least dozens. But I have to add that I couldn't have written a book like that, and I'm glad I didn't try.

I traveled quite a lot with Paul Farmer, and some of those trips were, collectively, like a harrowing of hell for me—to the famished, deforested Central Plateau of Haiti; to a periurban slum outside Lima, Peru, which, as the residents say, looks like the surface of the moon; to Moscow's Central Prison, where what the doctors described as an "uncrowded cell" contained fifty patients coughing up drug-resistant TB bacilli. In those places, particularly, Paul Farmer showed me more reasons for despair than I've ever seen before, or indeed imagined. And yet it was the most exhilarating experience of my life. PIH was still pretty small then, back in 2000, and yet they were creating vivid proof that diseases which could be treated successfully in the developed world could also be treated successfully and economically in some of the poorest, most difficult settings imaginable. That was the moving thing for me. Seeing the proof.

We also went to less difficult places. Havana, Cuba, for instance. We spent most of our week there in the company of a world-class infectious-disease doctor named Jorge Pérez Ávila, who all by himself—by example, as it were—corrected some of the prejudices I brought with me to Cuba. Years of bad publicity had left me imagining the place as gray and rather colorless, puritanically Stalinist. One night we ended up in the bar of a fancy hotel, renovated with European money. There we were fed dinner by the manager, a Cuban woman named Ninfa, a patient of Jorge's. At some point, Jorge turned to her and said, in words like these, "Ninfa. That is such a lovely name. But how did your parents know when you were born that you would be so beautiful?" Ninfa smiled, and turned to me. "Jorge has a very special way with all his female patients," she said. "We all want to sleep with him."

I began to sense that Cuba was a place where one might be able to have a pretty good time. I already knew that Paul Farmer's idea of a really good time was to visit patients. In Cuba, he did what he often did in other places where he had no patients of his own: he borrowed some from other doctors. Anyway, visiting patients also was Jorge's idea of rip-roaring fun, so that's what they did, while I tagged along. They visited Jorge's patients, mostly women, most of whom were pregnant. And after a while I would say to Jorge, "Is this patient pregnant, too?" just to hear his answer, which was, invariably, "Yes, but it is not my pregnancy."

I remember going on rounds with Paul and his students at the Brigham and Women's Hospital in Boston many times—evenings that would stretch late into the night, nights that were always the oddest mix of the comical and serious, yet always a cheerful experience somehow, rounds at the Brigham with Dr. Farmer, maybe because every tool ever invented for repairing patients was right at hand.

I remember a fashion show that the TB patients at Zanmi Lasante in Haiti put on, to celebrate Paul's birthday—I was sure that party would find its way into the book I was going to write, but it didn't, perhaps because I was laughing so hard at one moment and felt so enchanted the next that I couldn't take adequate notes. I remember Mamito, the matriarch of Zanmi Lasante, scolding me for something Paul had done about fifteen years before—scolding *me* because Paul had asked me, really almost begged me, to intercede on his behalf and explain to her why we had gone on an eleven-hour hike. I remember long treks and conversations with the wonderful, hot-headed Ti Jean, who built God knows how many houses for the poorest of Zanmi Lasante's patients. Ti Jean once carried me across a river. Another time he fed me and Paul a dinner of guinea fowl and Barbancourt rum. I miss him. He had a habit of telling Paul to shut up when Paul dared to interrupt one of his discourses—and the interesting thing about those moments was that Paul actually would shut up.

Then there were the christenings of patients' newborn babies—in Peru, for instance—with Paul in the role of godfather. This summer in Rwanda, I learned that this happens in Africa, too. And I found myself thinking, This is pretty cool, the guy has godchildren all over the world, more godchildren than a mafia don.

I remember quite vividly watching Paul testify in a grubby little courtroom in New York City—the INS was trying to deport a Haitian man with AIDS, and Paul was testifying to the effect that sending this man back to prisons in Haiti was tantamount to torture. The district attorney seemed like a pretty tough cookie, but after listening to Paul describe conditions in Haiti, she stopped putting up any fight at all and started asking him questions that seemed calculated to injure her case. Periodically, as I recall, this prosecutor would exclaim, "Good God! I had no idea it was that bad!" And I also recall that, on the way to the courtroom, Paul started worrying that his necktie was too flamboyant to wear before a judge. He insisted I give him my much more conservative tie. I still have the fiery red one that he gave me in return, though I do not wear it.

Finally, there was a night in Moscow. A congenial dinner with a famous personage in public health. By day Paul had been arguing with him. The fight had to do with milk: Paul wanted Russian prisoners with TB to get a glass of milk each day, and the public health expert didn't think this was necessary. I drank a therapeutic amount of Côtes du Rhône at dinner. Afterward, walking down a snowy Moscow street in the dark, I needled Paul a little. I may have recited a line I heard many times from people in the business of international health, which goes like this: "Doctors are very nice. They think the patient in front of them is the most important thing. But we care about something more important, which is the health of populations." I repeated something like that and then said of our dinner companion, "He's interested in public health."

"I'm interested in public health, too!" said Paul. "But what is the public? Is it a family, a village, a city, a country? Who are these people to say what the public is?" He was smiling. I think he'd had a therapeutic dose of Côtes du Rhône, too. His tone was jocular, but by then I knew that jocularity was often the tone in which he disguised statements of great importance to him. And I've been turning that statement over in my mind ever since, The Moscow Statement, as it were.

Partners In Health doesn't have all the answers as to how to go about fixing the dreadful poverty and disease that afflict billions of people today. I don't think anyone in the organization ever said they did. And even if they did have all the answers, they couldn't bring the terrifying pandemics of AIDS and TB and malaria under control all by themselves, any more than Paul Farmer could have created and nurtured Partners In Health all by himself. But they have shown the world that it is possible to control those diseases and to redress some of the underlying causes that have turned those diseases into pandemics. In some cases, with multidrug-resistant TB, for instance, they have given the world precise prescriptions, and they have made it possible for poor countries to use those prescriptions—largely thanks to Jim Kim, who figured out how to drive down the prices of the necessary drugs by about 90 percent.

But what they have done above all, I think, is to present both a rebuke and a challenge to the United States and the other wealthy countries and to offer all of us a real kind of hope, hope backed up by fact. They have done this, I believe, by paying attention to the needs of individual patients, in Haiti, Peru, Russia, Boston, and now Africa. It has been individual patients, people just like you and me, who have taught them how to treat a family, a village, a city, a country, maybe the world.

Introduction

The Right to Claim Rights

Haun Saussy

"*BAGAY KI PA SENP* / STUFF THAT IS NOT SIMPLE"

People sometimes refer to Paul Edward Farmer, MD, born in 1959, as a hero, saint, madman, or genius. Any or all of these descriptions may hold—but the essential thing about him is that he listens to his patients.

In the earliest piece of writing collected here ("Bad Blood, Spoiled Milk," from 1988), the young Paul Farmer, anthropologist, epidemiologist, doctor to the poor, gives an informant the last word:

> I consulted [Madame Gracia] regarding the ingredients of the herbal remedy for *move san/lèt gate*. Her response, and the tone in which it was delivered, brought me up short: "Surely you are collecting these leaves in order to better understand their power and improve their efficacy?" Had she added, "If you think we'll be satisfied with a symbolic analysis of *move san/lèt gate,* you're quite mistaken," I would not have been more surprised.[1]

As if Madame Gracia were telling Paul: "Here's the information you requested; do not file under 'Folklore.'"

A similar scene of instruction occurs early in Tracy Kidder's *Mountains Beyond Mountains.* A research project in rural Haiti had begun with the assumption that patients' beliefs about how they contracted tuberculosis—did they think it was caused by microbes or by sorcery?—made a difference for compliance and outcomes. The results of the study, however, showed no relation between belief and the results of treatment; the main factor influencing cure rates was the availability of food and social support. This might have meant that culture was irrelevant to practicing medicine in the Third World, a conclusion that this anthropologist-in-training was loath to adopt. Thinking that perhaps his own skills in eliciting tacit attitudes about sorcery were to blame for the discordant conclusions, Farmer began reinterviewing patients. Kidder describes him speaking to “a sweet, rather elderly woman”:

> When he had first interviewed her, about a year before, she’d taken mild offense at his questions about sorcery. She’d been one of the few to deny she believed in it. “Polo, *chéri,*” she had said, “I’m not stupid. I know tuberculosis comes from people coughing germs.” She’d taken all her medicines. She’d been cured.
>
> But now, a year later, when he asked her again about sorcery, she said that of course she believed in it. “I know who sent me my sickness, and I’m going to get her back,” she told him.
>
> “But if you believe that,” he cried, “why did you take your medicines?”
>
> She looked at him. He remembered a small sympathetic smile. The smile, he thought, of an elder explaining something to a child—in fact, he was only twenty-nine. “*Chéri,*” she said, “*èske-w pa konprann bagay ki pa senp?*” The Creole phrase *pa senp* means “not simple,” and implies that a thing is freighted with complexity, usually of a magical sort. So, in free translation, she said to Farmer, “Honey, are you incapable of complexity?”[2]

Both of these tales end with an abrupt change of focus, an epiphany. Part of the change is evidenced by a stylistic shift in which the remarks of the Haitian informant are translated into language that we are more likely to attribute to a graduate seminar than to dwellers in palm-frond huts with dirt floors. The shift in linguistic register mirrors a change in the tacit rules of the conversation between doctor and patient or between anthropologist and informant: the person conventionally assumed to be tongue-tied—the patient, the layperson, the primitive—seizes authority over the discussion, redefining its subject and purpose.

At such moments, the reader has the sense of a new narrative opening. The future—like the futures to which the last pages of *Old Goriot, Great Expectations,* or *Crime and Punishment* deliver their characters—will be different. Dr. Farmer learns from his patients. Their stories change the story he tells and the way he tells it.[3]

Medicine is both a formidably walled fortress of specializations and a standing rebuke to specialization. It is perhaps the one true humanistic discipline. Everything that impinges on the human species, from chemistry to psychology, from particle physics to marital discord, falls under its survey. When your case becomes serious, the general practitioner gives way to the cardiologist or the oncologist, who may send you to see a further, even more minutely focused, specialist; but an adequate explanation of what has gone wrong with you, as opposed to the remedies to be applied to its effects, may demand the talents of the geographer, the economist, the historian, the hydroelectric engineer, the novelist.

Your feelings of despair may interest both the researcher of neuronal networks, armed with sensors and magnetic-resonance imaging machines, and the chronicler of the fading American auto industry, whose local subsidiary recently folded and left you with a mortgage to pay and only so many months of unemployment compensation. Case studies are never one-dimensional. The inherent multiplicity of medicine declares that things are "not simple," while also showing that they are never without reason.

Complexity—the ability to negotiate among widely variant frames and scales of explanation—is a necessity in Paul Farmer's chosen terrain. A given person's disease is both a biological event with microscopic agents and a social event with human determinants, some of them (for example, trans-Atlantic slavery) reaching back hundreds of years and involving millions of strangers in related patterns of action. Rudolf Virchow had in mind housing, diet, working conditions, and birthrates when, even in the pre-microbial era, he designated doctors "the natural attorneys of the poor."[4] In recent years, medical training has been broadened to include reflection on social and cultural factors of illness, not just clinical ones. Attention to such causes makes for better doctors and more perspicuous diagnoses. But the essential thing is to clarify the relations among biological, economic, social, cultural, and other determinants of disease, not to use one of these dimensions as a cover for impotence in another. Much of Dr. Farmer's effort has gone into a polite, persistent struggle against the "immodest claims of causality" that doom certain sick people to an epidemiological dungeon whose outlines precisely match their cultural dungeon.

We have a striking example from early analysis of the AIDS epidemic. Reporting, on June 24, 1983, on the basis of 1,641 HIV cases verified in the United States and Puerto Rico, the U.S. Centers for Disease Control observed: "Groups at highest risk of acquiring AIDS continue to be homosexual and bisexual men (71% of cases), intravenous drug users (17%), persons born in Haiti and now living in the United States (5%), and patients with hemophilia (1%). Six percent of the cases cannot be placed in one of the above risk groups."[5] Four risk groups and one "undetermined" group adding up, with suspicious neatness, to precisely 100 percent, as if it were impossible for a person to be, for example, a bisexual intravenous drug user of Haitian origin: the CDC's statistics show the usual flaws of rough-cut data gathering and do not begin to frame an explanation. Of the categories, one is definable genetically (absence of a clotting factor in the blood), two are definable by behavior (a history of engaging in certain sex acts or taking drugs in a certain way), and one is a matter of nationality. It makes no sense for the total of five such categories to amount to 100 percent, except as an artifact of the process by which the data were gathered. A more cynical and accurate description would have read: "In 71% of cases, the examining physician chose to check off the box marked 'homosexual man'; in 17%, the doctor marked 'drug injector,'" and so forth.

But despite these obvious flaws, the CDC's report on an as yet little-understood disease could be—and was—read as an epistemological riddle. *What do gay men, heroin addicts, Haitians, and hemophiliacs have in common? The answer might explain AIDS!* And so, with biomedicine slow to deliver its suspect (the responsible "agent"), the sciences of behavior leapt in to answer a poorly posed question with the tools of ethnography, rumor, and prejudice. Leaving hemophiliacs aside, and picking up the hint in the CDC report that the unknown agent was most likely transmitted through the blood, journalists, abetted by anthropologists, connected the dots in a fantastic shower of clichés: blood sacrifice, pederasty, barbarism, black magic. The *Journal of the American Medical Association* lent its professional majesty to the question, "Do necromantic zombiists transmit HTLV-III/LAV during voodooistic rituals?"[6] If this is medical anthropology, neither the medical personnel nor the social scientists did much honor to their professions by joining forces. To be sure, the disease was poorly understood, and a range of divergent hypotheses about its origin and transmission were, quite legitimately, being explored. And the gamut from blood to behavior to passports testifies once more to the inherent multidimensionality of medicine. But one would not have to be a Haitian to have felt at that moment that less interdisciplinarity, rather than more of it, would have been a good thing.

In those early years of the AIDS epidemic, Paul Farmer was a medical student at Harvard who spent most of his time helping out at a clinic in rural Haiti while also doing research for his doctorate in anthropology. He was in a good position, therefore, to replace bad interdisciplinarity with good. A sense for complexity ought to enlarge medicine by prompting investigators to trace the effects of behavior, culture, and economy on disease sufferers. The interdisciplinary task of these investigators would be to account for the inputs of these factors to the organism, not to guess wildly at the implications of category labels. (The hapless speculators would have made less of a foolish impression, besides, if the connotations of their categories—for example, that of "Haitian"—had been backed up with actual experience on the terrain: what does it *imply,* in terms of behavior and social networks, to be a Haitian immigrant in the United States?)

Farmer's essay "The Exotic and the Mundane: Human Immunodeficiency Virus in Haiti" (1990) and his book *AIDS and Accusation: Haiti and the Geography of Blame* (1992) showed the reasons for the association between Haitians and HIV. It had nothing to do with voodoo rites, African bloodlines, or other excuses for projecting impurity onto a tiny Caribbean nation, and a great deal to do with poverty and the desperation that drove country people to the city and reduced them to selling their bodies to tourists and their blood to commercial agencies. The wish to blame AIDS on Haitian immigrants appeared to be the latest rationalization for a longstanding prejudice, and the explanation for those "immodest claims" was to be found in "the North American folk model of Haitians."

The reversal implicit in the phrase "folk model"—for once, the Haitian version of world history being able to frame the other as a mere ethnographic curiosity—must have given Farmer a bitter satisfaction. At issue, however, was not denouncing sloppy scholarship or staring down stereotypes, but demonstrating the ease with which statistics, history, and pathology could be overwhelmed by an account of disease that was both wrong and utterly "simple." Of all the points of view recorded in *AIDS and Accusation,* the ones least often in accord with the findings of epidemiology are those of popular journalists, those amateur social scientists whose "knowledge base" often cannot tell rumor from well-established fact, yet who have tremendous powers of influence precisely because they tend to confirm what their public already believes.

Haitian villagers, on the other hand, gave accounts of disease history and transmission that seconded the conclusions of the virology labs. HIV crept along channels of inequality in the body politic. It took advantage of the many situations of sexual contact where one party had the edge and the other party had no choice: where one party was, typically, a U.S. tourist, a Haitian soldier or paramilitary, a truck driver, or a local bigwig; and the other was, typically, a handsome young man or woman who had left the poverty of the countryside to seek a better life doing menial labor in town. Haitians, especially poor rural Haitians, were not to blame for HIV; if anything, it was another curse among many visited on them from outside. So said the virology; so said the country people. The nonsense shouted about AIDS and Haiti gave Paul Farmer early lessons in how to think, and how not to think, about the diseases of the poor. It wasn't that rural Haitians' theories of disease transmission were superior or that the witnesses were monotonously truthful. One had to know how to listen.

THE OUTCOME GAP

"Blaming the victim"—in this instance, casting the sufferer as the source of the disease—is a crude version of a strategy of despair that Farmer has repeatedly challenged in his career. Many of the essays included in this volume document and counter the temptation to make social science the cover for ineffective or nonexistent medical treatment. Sometimes the excuses for which slapdash ethnography substitutes are comically transparent. For example, before the President's Emergency Plan for AIDS Relief, initiated in 2003, reversed standing priorities, officials of the U.S. Agency for International Development and the Department of the Treasury occasionally contended that distributing antiretroviral remedies to Africa and Asia would be irresponsible and futile because people in these regions lacked "the Western sense of time" and could not be taught to take their medications at regular intervals; the lack of paved roads and the absence of refrigeration (neither essential to delivering first-rate HIV care) were brought up as well.[7] Past experiences of failure in tuberculosis control were mustered up, too, bolstered by reductive, anecdotal accounts of culture that blamed "noncompliance" with the prescribed regimen on the patients' irrational beliefs or general fecklessness.[8] Good medicine was not to be wasted on undeserving people—and rather than adapting to poverty and decrepit infrastructure, or addressing as yet unknown beliefs that might drive patients away from clinics that offered antiretroviral therapy, critics preferred to exile the sufferers to a forest of dubious sociological constructs.

Social medicine, according to Paul Farmer and the medical charity he founded in 1986, Partners In Health, does not consist of ordering up social science research that justifies medical inaction. Rather, it is directed at identifying the obstacles to care and removing them. Often, the most obvious obstacle is the price of drugs, and it is usually sufficient to prevent the topic of effective treatment for poor people with maladies like HIV, cancer, or multidrug-resistant tuberculosis from ever coming up. To account for instances where drugs are within reach but beyond many sufferers' budgets, a considerable literature exists on the problem of patient "compliance." In the experience of PIH, the problem usually resides with the services offered, not the patients. When tuberculosis or HIV patients have to choose between buying pills and feeding their families, the result, more often than not, is missed appointments. When patients enrolled in a TB or AIDS program receive medicines along with food that can help to replace their lost incomes, compliance is no longer a problem, and cure rates rival those in the wealthiest, best-equipped settings. To this way of thinking, social medicine does not just analyze the social factors that contribute to populations' susceptibility to disease; it seizes on certain organizing principles of society (here, the market model for distribution of goods and services) and reworks them for the sake of medical efficacy.

In a series of medical journal articles in 2001 and 2002, Farmer and colleagues presented their model for treating HIV in settings of extreme poverty.[9] The model—including free voluntary testing and counseling; provision of antiretroviral medications, food, and social services; and daily accompaniment by community health workers, all free to the patient—was patterned on programs that the same group had used in treating multidrug-resistant tuberculosis in Peru, Haiti, and Siberia.[10] Writing in the *Bulletin of the World Health Organization,* Farmer's group reported on Haitian HIV sufferers who were being treated with antiretroviral medications:

> The clinical response to therapy was favorable in 59 of the first 60 patients (over 40 more were enrolled in 2001). We estimate that 48 of these patients were able to resume working and caring for their children. The weights of all but two patients

> increased by more than 2 kg within the first 3 months of therapy. In a subset of 21 DOT-HAART [directly observed therapy with highly active antiretroviral therapy] patients whose viral loads were tested, 18 (86%) had no detectable virus in peripheral blood. This suggests that therapy was quite effective. Most studies based in the USA demonstrate viral suppression in only about 50% of patients after one year of treatment. . . .
>
> The provision of life-saving care through the HIV Equity Initiative has had a favorable impact on staff morale. It is our belief that the stigma associated with AIDS has diminished as a result of dramatic responses to therapy. . . . A related consequence of introducing DOT-HAART is an increased use of the clinic's free HIV testing and counseling services. . . . Thus the provision of AIDS treatment has strengthened AIDS prevention.[11]

Beyond the immediate public of specialists in medicine and public health, the articles were addressed to the various factions implicated in one way or another in the AIDS crisis—governments, nongovernmental organizations, international bodies, charitable foundations, activist groups—and in not too roundabout a way sought their support. As the authors pointed out, "the DOT-HAART project described above is so small [1,350 patients diagnosed, approximately 150 of whom received antiretroviral therapy] that it would not merit attention in the public health literature if we could point to larger and better studies that respond aggressively to the growing challenge of HIV. Because we cannot, we hope that our experience might be instructive in other settings where HIV and poverty are the top-ranking threats to health." That is a quiet way of stating that PIH's efforts in the Central Plateau of Haiti were unique and ought to be emulated elsewhere.[12]

But how? And who would pay? Although no price tag was given (the authors acknowledged support from Partners In Health donors, hospitals, and foundations), at several points the article referred to "objections to the treatment of AIDS with HAART, including those of unfeasibility and patients' non-compliance."

> Our own attempts to obtain funding were often met with resistance on the grounds that the project would be unsustainable in a country as poor as Haiti. . . . We estimate that 75%–80% of project expenditures have been for medications. . . . Most regimens cost more than US$ 10,000 per year per person. . . . At such prices . . . the implementation of HAART in a poor country, even with the DOT-HAART approach to assure compliance, is considered in international medical and public health circles as neither sustainable nor cost-effective.[13]

The concluding section sharpened the ironies and all but implicated the very concept of "sustainability" wielded in those "international medical and public health circles" as a co-factor in the ongoing epidemic:

> If HIV reveals a lack of basic primary care services for the poor, an aggressive response to this comparatively new disease may help to solve a host of old problems. High drug costs and the need for sustained monitoring have led many observers to conclude that aggressive treatment of chronic disease is neither feasible nor sustainable in those communities where the demand for treatment is greatest. The result is a growing "outcome gap" between rich and poor even as diseases become treatable by means of new medical technologies among people who have access to them.[14]

That sounds like a challenge. Responses by fellow experts in the same issue of the journal mainly sidestepped it. They chose not to address the objection to the criterion of "sustainability," or they simply repeated the words "neither feasible nor sustainable"; and some, in their recommendations, loaded the potential programs that might follow the model of PIH's pilot study with even greater financial and technological burdens. Anthony Mbewu was reluctant to generalize from the PIH study:

> Farmer et al. provide a starting point, but many more clinical trials are needed to investigate the efficacy of antiretrovirals in prolonging life and improving the quality of life lived with AIDS in developing countries. . . . Initial diagnosis should include a CD4 count, as accurate diagnosis and appropriate selection of patients for treatment [are] crucial. Treatment of newly infected patients requires more research. . . . Even with the drastic reductions in price of ARVs, to US$ 350 per annum, they remain unaffordable for most developing countries. Even in an "upper middle" income country such as South Africa, per capita health care expenditure in the public sector is only US$ 88 per annum.[15]

Richard Feachem struck a note of pathos:

> My dilemma is that the world is still a long way from being able to make antiretroviral drugs, even if they were free, effectively available to the majority of the people who are infected with HIV. I wish that the world was different. I wish that poor countries were not so poor. I wish that the health systems of poor countries were not so dysfunctional. I wish that rich countries were far more generous in their support for health sector activities in poor countries. Regrettably, none of this is the case in the real world in which we live. . . .
>
> [The position that access to HAART is a human right] may be right in a moral sense, but it is not practical. To advocate the impossible is to put at risk the achievement of more limited objectives. . . . An international effort focused on establishing and sustaining a number of islands of learning and good practice is likely to make a greater contribution to the reduction of suffering and unnecessary death than spreading limited resources thinly across the low-income countries.
>
> The approach that I recommend is very difficult for international agencies to adopt, for obvious political reasons. It is, however, an approach that the major foundations can take. . . . Let us make sure that the best is not seen as the enemy of the good.[16]

Charles Gilks, Carla AbouZahr, and Tomris Türmen suggested that the outcomes reported by PIH were the epidemiological equivalent of bonsai and should be viewed with clinical skepticism:

> Farmer et al. present a remarkable achievement: the establishment of a care service for people with HIV/AIDS in a community of poor displaced people living in a remote rural area of Haiti. . . . If the claims of the authors are substantiated, such a model would have enormous potential for replication in other resource-poor settings. If, on the other hand, the authors' claims are exaggerated, the potential for doing more harm than good would be great. . . .
>
> The authors' main contention is that the concerns voiced about treating HIV-positive people with HAART—namely high cost of drugs, lack of health system capacity to deliver them effectively, possibility of non-compliance, and risk of drug resistance—are ill-founded. If we are to be convinced that this is so, we need better evidence than that provided in this paper. . . .
>
> By any evaluation criteria—whether cost-effectiveness, sustainability, feasibility, or absence of unintended negative consequences—this success story must be classified as non-proven. Yes, we know with exceptional circumstances, motivation, resources and generous research funding positive outcomes can be achieved, but replication is something else entirely. Yes, it is true that with huge inputs the miracle of anti-retroviral therapy will produce stunning successes. And certainly, acting when others have failed to do so is noble. However, for lack of appropriate design and scientific evaluation, important lessons that might have been applied in other settings simply cannot be drawn from this study.[17]

The discussion around providing antiretroviral therapy to penniless Haitians suggested that the Partners In Health initiative was, however "noble," potentially capable of "doing more harm than good." From the point of view of international aid institutions, the PIH model of treatment had many drawbacks. It would involve spending large amounts of money outside existing budgets and breaking down distinctions between medical, economic, and social forms of intervention. Moreover, it reversed the usual pattern of action in medical assistance programs. It sought, as the PIH doctors proudly put it, to "remove the onus of adherence from vulnerable patients and place it squarely on the providers."[18] Rather than waiting in their clinics for patients to come in and ask for treatment (and get the best treatment commensurate with their ability to pay), the doctors and their colleagues were being told to go out into the villages, find the people suffering from contagious diseases, and give them medication, food, and social support.

In addition, far from aiming at some "sustainable" future in which Haiti or Peru would carry the costs of epidemic illness, this plan recognized that the only way to make modern medicine happen in the poorest countries of the world was for the wealthy countries to pay for it. Without a doubt, the PIH clinicians and researchers were addressing the "outcome gap": whether substantially or symbolically remained to be seen. For the time being, Richard Feachem's predictions were borne out: PIH continued to depend on foundations for the greater part of its funding. Nonetheless, in 2002 the people of PIH had the satisfaction of seeing the World Health Organization adopt guidelines similar to theirs for treatment of multidrug-resistant tuberculosis in settings of poverty, and then of observing the creation of the Global Fund to Fight AIDS, Tuberculosis, and Malaria. In 2003, the WHO declared the HIV epidemic a worldwide public health emergency and announced its intention to see three million people who were living in poverty begin to receive antiretroviral therapies by 2005 (a goal reached sometime in 2008 and amounting to 31 percent of the estimated need).[19]

But none of this amounted to a general recognition of HAART (or whatever approach sets the highest contemporary standard of care) as a human right. Only that position makes health care for the poor sustainable, as PIH understands "sustainable." Foundations, like wealthy individuals with a hobby, can change their minds; religious or political groups can distort the medical agenda; indispensable local allies can drop out of the picture; the epidemics can and will go on growing.[20] What can argument, or even an excellent example, do in the face of the thesis (self-confirming by merely being pronounced) that "resources are limited" and "the world is like that"?

To put into context the faint praise ("acting when others have failed to do so is noble") bestowed on Partners In Health by a trio of WHO analysts, it is useful to point out that in 2000, AIDS had already killed more people than any epidemic since the worldwide bubonic plague of the fourteenth century, and yet "the quasi-totality of AIDS assistance to the [most] heavily-burdened countries . . . consisted of the promotion of education and condom distribution."[21] So ineffectual a response requires explanation. The reason cannot be medical, because the effectiveness of antiretroviral therapy was uncontroversial in the First World: thousands of men and women got up every day and went about their business thanks to the combination regimens devised in 1996, which turned AIDS into a manageable chronic disease. The justification for the "different standards of care—treatment for the affluent, no treatment for the poor"[22] and the consequent "outcome gap"—was presented in the language of economics: resources were scarce; it was not "cost-effective" to allocate drugs purely on the basis of need; the rationing of AIDS care had to be planned for guaranteed success.

But for Farmer and his associates, the issues could not be left in that language: they had to be translated into a logically and politically more powerful idiom. That was the only way to break out of the self-confirming loop described in a 2001 *Lancet* paper: "Funding for expansion of this pilot project [in central Haiti] was sought from a number of international agencies charged with responding to AIDS; all declined to support this effort on the grounds that the drug costs were too high to meet so-called sustainability criteria. Pharmaceutical companies were approached for contributions or concessional prices but referred us back to the same international agencies that had already termed the project unsustainable."[23]

The language that came naturally to Partners In Health in describing this predicament was philosophical and moral. Abandoning the vast majority of AIDS sufferers to their fate had to be presented and constantly re-presented as a moral and political decision that inscribed in the flesh of millions of people the differential valuation of human lives that had currency "in the halls of power" (to use the customary Farmer shorthand). The horrible irony of tuberculosis—that "the advent of effective therapy seems only to have further entrenched [the] striking variation in disease distribution and outcomes" between rich and poor—had recurred for these new plagues. The fact that the poor were condemned to die of treatable diseases like AIDS and TB symptomatized the condition of "structural violence" (another piece of Farmer shorthand); it emanated from decisions that had to be framed as political and moral, not technological, arithmetic, or biological.[24] In the compound noun "social medicine," the social analysis once more had to lead the medical application.

"A CERTAIN PERCENTAGE"

Early in *Crime and Punishment,* Raskolnikov, who has not yet advanced to ax murder, is wandering the boulevards of St. Petersburg and comes across a sixteen-year-old girl in a torn dress, drunk to the point of blacking out and already attracting the interest of a predatory-looking older man. Raskolnikov calls a policeman and attempts to send the girl home in a cab. His rescue plan fails, and as the girl, her would-be admirer, and the policeman move down the street, Raskolnikov consoles himself with the then-new science of statistics:

> "Poor girl! . . . ," he said, having looked at the now empty end of the bench. "She'll come to her senses, cry a little, and then her mother will find out. . . . First she'll hit her, then she'll give her a whipping, badly and shamefully, and maybe even throw her out. . . . Then right away the hospital . . . well, and then . . . then the hospital again . . . wine . . . pot-houses . . . back to the hospital. . . . in two or three years she'll be a wreck, so altogether she'll have lived to be nineteen, or only eighteen years old. . . . Haven't I seen the likes of her? And how did they come to it? Just the same way . . . that's how. . . . Pah! And so what! They say that's just how it ought to be. Every year, they say, a certain percentage has to go . . . somewhere . . . to the devil, it must be, so as to freshen up the rest and not interfere with them. A percentage! Nice little words they have, really: so reassuring, so scientific. A certain percentage, they say, meaning there's nothing to worry about. Now, if it was some other word . . . well, then maybe it would be more worrisome. . . . And what if [Raskolnikov's sister] Dunechka somehow gets into the percentage! . . . If not that one, then some other?"[25]

A few pages further on, an overheard conversation in a tavern sets Raskolnikov to thinking of the elimination of one aged money-lending woman as the spark to a vast operation of moral accounting: “Hundreds, maybe thousands of lives put right; dozens of families saved from destitution, from decay, from ruin, from depravity, from the venereal hospitals—all on her money. Kill her and take her money, so that afterwards with its help you can devote yourself to the service of all mankind and the common cause: what do you think, wouldn’t thousands of good deeds make up for one tiny little crime?”[26]

If not that one, then some other, Raskolnikov thinks about the girl on the way to a life of trouble; *let that one bear the cost for many others,* he thinks in the first intuition of what will become his own defining crime. In both cases, his thinking about the lives and fates of others is “simple”: a person is a data point, the consequences of his or her elimination are calculable in terms of benefit and loss.[27] Only the thought of a particular person—his sister Dunechka—arrests (momentarily) his calculation.

The framers of health care budgets, especially in the age of AIDS, are in Raskolnikov’s world, although it must be said, to their credit, that they are not comfortable there. In what are known as “resource-poor settings,” the market—that is, patients’ ability to pay—will supply neither prevention nor cure. In the experts’ jargon, prevention is “cost-effective” and treatment is considered not to be so, absent the ability to pay for it. If the goal is “to save the most years of life with the funding available,” prevention may look like a rational choice—supposing that it works.[28] But measures of the success of prevention will become available only in the long run and only in the aggregate (when that population’s rate of infection is observed to shrink in proportion to the progress of the disease elsewhere), and prevention does nothing for the people who have already been infected. To give priority to prevention is to sentence them to death—almost to urge them to get out of the way so that the serious business of prevention can start. And as Farmer has often observed, no one is suggesting that prevention be the dominant or only approach to AIDS in the wealthy countries of the world; the rationale of “cost-effectiveness” is applied selectively in keeping with political and economic inequalities that are no secret to the people who suffer from them.

If availability of resources is the problem, the history of modern epidemics suggests another interpretation of the slogan “cost-effectiveness.” Multidrug-resistant tuberculosis emerged because drugs were rationed improperly, ensuring not that patients were cured but rather that the bacilli invading them were vaccinated against first-line therapies. The history of the Ebola outbreak gives a more vivid illustration. The nuns in charge of a charity hospital in Sudan evaluated the funding available to them and determined that five hypodermic syringes were the maximum that could be supplied to their clinic each day. Rinsed occasionally in a pan of warm water, those syringes passed through the skin of hundreds of patients. In short order, an unanticipated virus felled first the patients who had received injections, then their family members and others who had come into contact with them, and finally the medical personnel themselves. Similar causes were involved in the second outbreak of the epidemic in Zaïre.[29] No one could deny that the staff of the charity hospital recognized the limitations placed on their resources—in this instance, syringes. They were responsible to their budget, but not to their patients, perhaps thinking that when medical care is provided as an act of charity, the relevant standard is that it be "better than nothing." In this case, however, what they provided was a great deal worse. One would not have to be a visionary to see that it would have been better to ask for more syringes, even if the budget suffered.

The problem with the Sudanese incident is that it too easily becomes an example of bad nursing rather than of bad priorities. And yet the nurses' blunder is of the same cloth as the "prevention versus cure" debate and the reluctance of drug companies and international bureaucracies to expand access to a First World standard of care. All these arise from resource stinginess, which aggravates a public health shortfall, turning it from a problem into an emergency. Before 2002, the World Health Organization and numerous governments were ready to spend money to show that they were concerned about tuberculosis, but they were not ready to spend enough money to cure the drug-resistant TB that was killing the patients and thereby rein in the epidemic in Russian prisons.[30] "Managerial successes, clinical failures": the title of one of Farmer's short commentaries neatly frames, by symmetrical antithesis, his personal policy.[31]

One form of complexity with which Paul Farmer constantly has to grapple is that introduced by differences of scale. The doctor does everything possible for the patient; the administrator does everything possible for the program; and a sense for complexity is needed where one might conflict with the other. (The term "sustainable" marks very precisely one such area of conflict: it was because Farmer was intent on sustaining his patients that potential donors judged his program "unsustainable.") Raskolnikov's logic always threatens and must be kept at bay.

Readers of Tracy Kidder's *Mountains Beyond Mountains* will remember the chapter about the medical evacuation of John, a small Haitian boy with a rare form of nasopharyngeal cancer. Serena Koenig, a Boston physician and Partners In Health volunteer, took an interest in John on one of her visits to Haiti and persuaded colleagues at Massachusetts General Hospital to waive the fees (some $100,000) for his treatment. But getting John to Boston was difficult: well over $20,000 had to be disbursed for John's preliminary biopsy, an ambulance to take him down the mountain to the Port-au-Prince airport, and a Lear jet to get him to the States. To top it all off, the surgeons at Mass General found that his cancer had spread to so many parts of his body that nothing could be done to save him. He died a few weeks later.

Could this be deemed both a managerial and a clinical failure? Administrators at the PIH clinic in Haiti worried about the consequences before deciding to go ahead:

> "What are we going to do if another kid like this comes to us? It's not a one-time thing. We're not going to close the hospital after this. It's really tricky. The staff will be asking why did they spend this money. . . ."
>
> "I'm looking at only one child," Serena said.
>
> "That's the thing," said Ti Fifi. "There are so many kids waiting for heart surgery, and the staff is asking for more money. A medevac flight is not something you do in Haiti. . . . I am sure that people will say, If your child is sick go to Cange and they will fly him to Boston. In the central plateau, this is going to be an event."[32]

The doctor's focus on the "one child" collides with the program manager's anxiety about the infinite number of possible patients and the impossibility of treating them all equally. The group's efforts to remedy inequalities in health care between Haiti and the United States, pursued uncompromisingly in this particular instance, might create in the minds of Haitians a feeling that John had been singled out for inequitably favorable treatment, while other people's children had not. (In the end, these fears proved groundless, but Kidder does not explore the reasons: do they come down to good luck or to the extraordinary forbearance of the residents of Haiti's Central Plateau?) The review committees that had turned down PIH's requests for funding for the HIV Equity Project, had they been asked, would never have authorized John's flight, even with free medical care awaiting him in Boston. Kidder writes: "A feeling lingered with me that the whole episode was like an object lesson in the difficulty of Farmer's enterprise, perhaps in its ultimate futility."[33]

Kidder's narration of the episode brings out the awkward choices that PIH faced. A lot could have been done with $20,000. Raskolnikov might have found it expedient to delay the ambulance and use the money originally earmarked for John toward the good of the greater number. But that would be adopting the manager's position rather than that of the doctor, who quite rightly has the primary duty of advocating for her patient so long as the patient has a chance of being cured. And vetoing the child's evacuation would certainly not be adopting the patient's position. Raskolnikov might also have argued that, given the "percentage" of children that die from various causes every year in Haiti, withholding care from one more child would not add perceptibly to the catastrophe. If not this small boy, it would surely be another one; why single out this boy for a comfortable death? In Kidder's account, the doctor's perspective is the one that starts and ends with the plain bump-on-a-log of indelible fact: "'What will I say if I'm asked why we're doing this?' 'That his mother brought him to us,' said Farmer. 'And we're doing everything we can to help him.'"[34]

Complexity consists of maintaining the chance for the doctor to act as a doctor, proceeding as if there were only this one patient in the world. You don't "scale up" from the individual patient to the program, any more than you apply precisely the same feelings to the love of another person and to the love of humanity.[35] Pressures familiar in the world of medical insurers and "managed care"—pressures to contain costs, to maneuver the patient's ration of care toward the statistical mean—operate a thousand times more stringently in the realm of grants and assistance programs among the poor. Ingenuity, an irrational degree of effort, and the kindness of strangers have so far kept the budget of Partners In Health from being a restraint on the doctor's sense of priorities. The far goal is to transform institutions to the point that "because his mother brought him to us" is an explanation that evokes no protest.

VIABILITY

Skepticism about Paul Farmer and Partners In Health is often expressed with two related words, "sustainability" and "viability." Often while expressing admiration for the work of PIH, critics contend that the work is not sustainable, that it relies on the efforts of a small band of unreasonably decent people, that it cannot survive its founder, that it would evaporate were it not for an ever-increasing stream of charitable donations, that it creates an undesirable dependency of the Third World on the kindness of the First. The objection to dependency expresses itself in a curious variant of the metaphor of vitality. If maintaining PIH's patients in a state of viability comes at the price of making its programs appear nonviable, the very viability of PIH, its ability to sustain itself and grow, relies, in these critics' reading, on a kind of artificial life support doomed to collapse one day.

"Sustainability," "viability"—words redolent of good intentions, of careful planning, of stewardship and long-term forethought. Their very modesty makes them attractive. Rather than promising immediate utopia, they point to means of carrying on somehow, with limited expectations. The violence they contain is, if anywhere, well under the surface. But philology can bring it out.

The term "viability," originating in French, moved into English in the middle nineteenth century. The *Oxford English Dictionary* summarizes: "VIABILITY. The quality or state of being viable; capacity for living; the ability to live under certain conditions. Also *transf.:* now *esp.* feasibility; ability to continue or be continued; the state of being financially sustainable. In common use from c. 1860."[36] A little narrative, familiar in its outlines, inhabits the sequence of meanings given here: the word is said to depart from a core meaning that is human in connotation (what could be more intimately associated with humanness than "living"?) to extend its anthropomorphism to new and alien objects, such as defense policies, business plans, political programs.[37] Just as the human infant emerges from its initial life-support system, the mother's body, and begins to take air and nourishment from outside, eventually to stand autonomously on the ground of adulthood, so enterprises, policies, and so forth begin as uncertain projects needing investment or other inputs and eventually come to a self-sustaining maturity, or don't. As the *OED* observes, the standard uses of the term today are those referring to the nonbiological contexts; there has been not just an extension but a migration of sense. Thus the *OED* inserts the tag "*transf.*," indicating metaphorical transfer, between the biological and nonbiological contexts of use.

The word "sustainable" (a near-synonym of "viable") is a migrant from the sphere of engineering and environmentalism to that of business, and thence to that of political economy. Buckminster Fuller is responsible for the major shift in the word's meaning, through his speeches and activism on behalf of long-range planning and management of "Spaceship Earth."[38] With finite resources, how long could consumer societies prevail before consuming the very basis of their existence (air, water, food, raw materials)? Fuller's vision of a future economy would maximize the utility of the minimal resources extracted from the environment. A business is termed sustainable when its sources of income are expected to durably exceed its outlays. When used by specialists in international economics, the term refers to a fantasy in which the costs of development (say, the building of a health care infrastructure) are borne by the beneficiaries, something that was certainly not the case for Europe during the Industrial Revolution and is unlikely to occur elsewhere.

"Viability" and its predecessor, the adjective "viable," are words invented at a particular moment, having particular contexts of use and particular dimensions along which they extend themselves. The word *viable* first appears in the anonymous French translation of Castiglione's *Il Cortegiano* (The Courtier) published at Lyons in 1537.[39] At the textual juncture in question, Castiglione's assembly of learned and courtly persons is debating whether women are suited for public office, and one speaker contends that women, being better equipped for natural survival than men, ought to have at least the equivalent privileges in social life. The reason, couched in the "four humors" medical language of the time, is that "temperate bodies are most perfect . . . woman, taken in herself, is temperate, or at least more nearly temperate than man, because the moisture she has in her is proportionate to her natural warmth, which in man more readily evaporates and is consumed because of excessive dryness. . . . And thus, since men dry out more than women in the act of procreation, it frequently happens that they are not as *viable* as women."[40] Reckless expenditure contrasted with reserve and internal balance: the "viability" here ascribed to women exhibits the properties that would later, in a world with a different physics and a different economics, be designated by the word "self-sustaining."

The French translator added a discrimination of meaning to Castiglione's Italian, and a new word to the French language, for here the Italian text says *"spesso interviene che sono meno vivaci che esse." Vivace* is a correctly formed word in Italian, and the cognate *vivace* already existed in French (it is found in Rabelais and Montaigne); but French *vivace* did not specify how "endowed with life" should be taken, whether it indicated a degree of intensity or a degree of duration.[41] The context emphasizes longevity, not just liveliness; *viable,* it turns out, is the adjective that conveys a prediction of duration on the basis of preexisting qualities.

The main distinction introduced into French by the word *viable,* the asserted distinction between mere life and durable, self-sustaining life, gives opportunity for a further distinction on the border between medicine and law—two bodies of knowledge that perch nervously over the definition of life. For certain French legal purposes, such as assigning paternity or assigning guilt in cases of infanticide or abortion (turning out differently according to whether the child *would have* been expected to live), it is not enough that a child be born alive; it must be born both *alive and viable,* and the one condition does not entail the other.[42]

But the full meaning of the distinction between the French terms *en vie* (alive) and *viable* emerges in court cases centering, as if written by Balzac, around multiple deaths and disputed rights of succession to property. Here the Roman law, always touchy about family matters, provided guidance. "The child who comes dead into the world is not considered a child; it is not even a person," writes Alexandre Duranton in 1844, backing himself up with Justinian in the *Digests:* "Those who are born dead are deemed neither born, nor procreated." They can be forgotten as far as property rights go. But what about the child that is born in a state between life and death? As Duranton argues: "The law requires not only that, in order to have the capacity to be someone's successor, a child not be stillborn; the law demands that the child be born viable, that is, with the necessary conditions for living, with the aptitude for life; that its conformation be such that, on seeing it, no one will say: He was born for nothing but to die at the instant, and not for life." Imagine two children, both of whom live for only an hour. The law will treat them differently according to whether or not they were suited and equipped for life, that is, "viable."[43]

At this historical stage of French law, then, a judgment of "viability" constitutes the child as a juridical person, not life per se.[44] The decision is a legal one, but judges cannot make it; only a doctor is entitled to assign viability. In an 1871 case judged by the civil tribunal of Narbonne, a father was required to prove "that the child was born, that it lived outside its mother's body, however short its existence may have been, and that it therefore constituted a legal person capable of receiving goods by way of inheritance and of transmitting goods in the same manner." The testimony supplied by the father in this case, said the court, was inadequate because "he did not offer to prove that the child cried out, or even that it took a complete breath; he did not offer to prove that anyone's hand felt a heartbeat through the child's chest; he did not offer to prove that a mirror had been put before its mouth and been fogged by its breath"—all traditional means of ascertaining life. Against the father's claim that the child was born viable, though admittedly not alive, the court contended that the only signs of life it had given were "convulsive movements" and an accidental influx of air into its nonfunctioning lungs during the doctor's attempt at resuscitation.[45] "Convulsive," "accidental": the magistrate's language makes the nonviable child out to be a machine or other arrangement of movable matter, not yet an animal, much less a member of our species.

The law is concerned with the doctor's opinion of whether the child *would have* survived, not with his report on whether it *did* survive. The question is whether it had everything that was necessary for an autonomous existence outside its mother's body, the touchstone of viability. The opinion that the child was "viable," that is, "organized for life" and capable of living without external help, whether or not it actually goes on to live, pulls the switch that makes the child a possessor of legal rights and, in the cases just cited, an inheritor. Without this medical blessing, the child has bumped against the limits of the social world but has not been admitted to any role within it. Any social role, even the minimal one of inheritor, must be claimed; it does not follow from the nature of things, as Duranton says with emphasis.

Not just a matter of marking the alternative of life or death, the term "viability" opens a place of judgment about what is and is not to be considered human. With the constellation of meanings it implies, it takes up from the Roman legal doctrine that excludes nonviable children from the status of humanity.[46] One of the possibilities it opens is eugenics.

The uncertain status of the premature or incomplete child between viability and nonviability—particularly uncertain now that the means of prolonging life and substituting for vital functions are so much more advanced than they were in the 1870s—is a link between those scenarios in which a claim to property hinges on a judgment of viable personhood and the contemporary contexts in which the word "viability" is most often pronounced, namely, ecological predictions. For although the need to reverse damage done to the environment is well documented, and such actions are plainly in the interest of future generations, those future generations have no legal forum at which to present their case. Before he or she can inherit, as Duranton points out, a person must have judicial standing, and judicial standing goes only to those who exist at the time that a right is conferred—exist, that is, in the full sense of being both alive and viable.

The distinction between *vie* and *viabilité* comes up for the purpose of resolving an uncertainty—Was the product of the birth a human child? Was it therefore eligible to inherit and transmit property?—and always under counterfactual conditions. *Had the infant in question lived, would it have succumbed to external causes or to a consequence of its own malformation?* No question of viability arises in the case of a child who lives. The word's power derives not from the defined expertise of the doctor or the lawyer, but from the interchange of their two disciplines. The doctor answers a question of no medical relevance just because the law needs it answered. The question to which the term "viability" corresponds is not really about life and death but about transmission, inheriting, bequeathing. The people for whom such judgments make a difference are never the persons about whom the judgments are made. Those inheritors and experts appear in the story of viability or nonviability as specters with the power to shape a narrative in which they have an interest, but of which they are not the objects. And, mirror-fashion, current predictions of the viability of the present forms of human culture, made by us, will have consequences not particularly for us, but for people who are not able to sit in on our discussions. The medical "viability" judgments come too late; the ecological ones come too early.

These scenes in which something not quite yet existent, or not quite up to the definition of living, knocks on the door and desires to be admitted can be recognized as well in the articulation among medicine, the economics of aid, and human rights that forms the complex, contradictory object of Paul Farmer's efforts. In its medico-legal usage, as when an inheritance hangs on the status attributed to the dead child, the term "viable" stakes out the uneasy frontier between ways of life and "mere life,"[47] between social and biological existence. That is, it describes its own hybrid field of meaning in performing the work it does. When the word moves into political vocabulary, it serves to predict an outcome and at the same time to assert the reality of the object of its predictions, to make something viable or nonviable. Chateaubriand, in 1833, wrote to the Dauphine about the July Monarchy: "Although the present monarchy does not seem viable, I fear that it will live beyond the limits one might predict for it." Victor Hugo, in 1848: "It is because I long for the Republic that I long for it to be viable, that I desire it to be definitive." George Sand, in 1870: "Be well advised that the Republic will be born again, and that nothing can forestall it; viable or not, it occupies every mind."[48]

When we assess the viability of an animal species, an economic program, or a political entity, we are, as part of the implication of the word, imagining it as already dead or moribund and of retroactively questionable legal standing (recall that the child deemed not viable is considered not to have lost the status of a person or inheritor, but *never* to have had it). Thus the word carries a certain verbal magic, reinforced by its association with the language of experts, the power to say *what would have been* or *what was going to be all along.* "Viable" is never entirely in the present tense, or entirely in any one moment. Because it links two moments, it tells a story and creates a potential subject: the child, the patient, the Republic, all figures of frustrated possibility in need of something they cannot supply themselves. One such thing that must be supplied from outside, a necessary but certainly insufficient condition, is a narrator willing to identify them as protagonists of a story, like Dr. Farmer defending his patients against the narrative in which they were only features of a different protagonist, the unhealthy budget. (For that matter, he also defended his unhealthy budget, on the grounds not that bankruptcy was admirable but that in this situation a balanced exchange between Haitian sick people and international development agencies was both impossible and immoral.) It is a matter of asserting their lives against a model of viability from which they were peremptorily excluded.

SUBSTANTIVE RIGHTS AND UNIVERSAL OBLIGATIONS

The assignment of viability is the precondition for human status: those not yet in being, or no longer in being, lack a forum in which to be heard. That condition of being outside the reach of rights is one they share with many people currently in existence. Before he or she can possess any legal rights, a human being must have ongoing biological existence: this lesson, implicit in the legal history of the term "viable," forms the basis of Paul Farmer's uneasiness with the usual language of human rights as spoken in this country. A longstanding dispute, alluded to in "Rethinking Health and Human Rights" and "Making Human Rights Substantial" (chapters 21 and 25 in this volume), divides those who see the core human rights issue as protecting individual autonomy from the encroachment of the state and those who see it as securing economic and social rights. This division follows old Cold War precedent, with the socialist bureaucracies claiming to derive their authority from their provision of subsistence to the people, and the capitalist forms of organization claiming to derive it from the consent of the governed.

For Farmer, the culture of human rights harbors a disastrous tendency to forget the fact that human bodies need sustenance and medical care before they can claim the freedoms enshrined in the Bill of Rights or similar documents. The right to claim rights, it seems, is what "structural violence" denies the poor, and it does this by threatening to take away that indispensable infrastructure that is a body or to take away the food, clean water, and appropriate medication that underwrite the body's survival. "It is when people are able to eat and be well that they have the chance to build democratic institutions," Farmer notes. Substantive rights form the basis of legal rights; the human body is the indispensable infrastructure supporting any legal or political claim. Not to get the sequence backward: that is how to restore the meaning of the misused term "viability."

Conversely, it makes a great difference for Dr. Farmer's patients and potential patients to maintain, as a medical expert might, that the right to claim rights, however moribund in the greater part of the world today, was not stillborn but has at least drawn enough breath in the course of human history to be registered as viable and thus to have legal heirs. What those heirs inherit is a claim on certain substantive rights, rights entailing a share in goods. A business, a church, or a charity may extend the same goods to people—food, first-rate medicine, housing, and even that much-trumpeted commodity hope—but it will be as an exchange or as a gift. Rights belong to the traffic that people have with states. The privatization of social services has notoriously created obstacles to medical care by subjecting patients to user fees and by withdrawing services once provided as a public good, but the primary harm done is to the contact between citizen and state, which is no longer based on a mutual claim of rights. Of course, in much of the world, and especially where the poor are at home, the state operates more commonly to take rights away from the people than to grant rights; but no other actor is under a universal obligation, however frequently breached, to provide for the common good. It is astonishing that Paul Farmer has seen the worst effects of predatory states both strong and weak—not to mention bandits, structural-adjustment programs, and drug lords—yet considers the protection of primordial rights to be the business of the state. Has the twentieth century, with its lynchings, pogroms, camps, gulags, exterminations, and bombings, passed him by?

Under the withering-away of the welfare state and the privatization of police power, little stands between "unaccommodated man" and brutal economic, environmental, judicial, and viral conditions. Russia, Haiti, and Rwanda, three of the countries where PIH is most active, can illustrate the point. Kidder captures the ambiguous relation between Partners In Health initiatives and their political context in a bold simile:

> In daylight, in an all but treeless, baked brown landscape, Zanmi Lasante [PIH's Haitian sister organization] makes a dramatic appearance, like a *fortress* on its mountainside, a large complex of concrete buildings, half covered with tropical greenery. Inside the walls, the world turns leafy. Tall trees stand beside courtyards and walkways and walls, artful constructions of concrete and stone, which mount the forested hillside. . . . There is running water, and you can hear a big generator churning out electricity. The buildings have tiled floors and clean white walls and ceilings. [emphasis added][49]

A fortress: in other words, a place where people can band together for protection; an enclave holding out against erosion, lawlessness, and disease. Zanmi Lasante appears as a rebuilding of the mission of government, an act of resistance to the abdication of state responsibility imposed on Haiti by external powers—in sum, a replacement for the missing state. (By extending rights and imposing peace, the "fortress" could be said to pass two minimal tests of statehood.) There is something paradoxical—or "not simple"—about this quasi-fortress, this model for a welfare state, built with private donations. The ambition that directs it—to persuade states to get back into the business of guaranteeing substantive rights, central among them the right to health care—will, if successful, resolve that paradox in time. Perhaps the leafy fortress on the hill is analogous to the pinprick of immunization, a particle of privatization meant to enable the body to overcome the disease.

NOTES

1. Farmer, "Bad Blood, Spoiled Milk," pp. 80–81. Also see chapter 1 in this volume.

2. Kidder, *Mountains Beyond Mountains,* p. 35. Kidder tells in anecdotal form the story Farmer presents in social science terms in the 1999 essay "Optimism and Pessimism in Tuberculosis Control" (which appears in Farmer, *Infections and Inequalities,* pp. 211–27, and is also included in this volume as chapter 8). Farmer mentions this dialogue later in Kidder's book: "The woman who said to me years ago, Are you incapable of complexity? That was an epiphany for me. Are you going to punish people for thinking TB comes from sorcery?" (p. 293).

3. For another study in which the format of patients' narratives serves as a diagnostic of social and biological change, see Farmer, "Sending Sickness" (chapter 2 in this volume).

4. Virchow, "Was die 'medizinische Reform' will," cited in Ackerknecht, *Rudolf Virchow,* p. 46; see also pp. 130–32 of Ackerknecht's book.

5. Centers for Disease Control and Prevention, "Current Trends: Acquired Immunodeficiency Syndrome (AIDS) Update—United States."

6. Greenfield, "Night of the Living Dead II." For a fuller account of these baroque scenarios, see Farmer, "The Exotic and the Mundane" (chapter 3 in this volume).

7. See Herbert, "Refusing to Save Africans."

8. See Farmer, "Social Scientists and the New Tuberculosis" (chapter 7 in this volume).

9. Farmer, Léandre, Mukherjee, Gupta, et al., "Community-Based Treatment of Advanced HIV Disease"; Farmer, Léandre, Mukherjee, Claude, et al., "Community-Based Approaches to HIV Treatment in Resource-Poor Settings"; Farmer, "The Major Infectious Diseases in the World—To Treat or Not to Treat?" (chapter 12 in this volume); Singler and Farmer, "Treating HIV in Resource-Poor Settings."

10. Farmer and Kim, "Community-Based Approaches to the Control of Multidrug-Resistant Tuberculosis"; Farmer, "Managerial Successes, Clinical Failures"; Furin et al., "Effect of Administering Short-Course, Standard Regimens in Individuals Infected with Drug-Resistant Mycobacterium Tuberculosis Strains."

11. Farmer, Léandre, Mukherjee, Gupta, et al., "Community-Based Treatment of Advanced HIV Disease," pp. 1147–48.

12. Ibid., pp. 1149–50. Cf. Kidder, *Mountains Beyond Mountains,* p. 257.

13. Farmer, Léandre, Mukherjee, Gupta, et al., "Community-Based Treatment of Advanced HIV Disease," pp. 1146, 1148.

14. Ibid., p. 1149.

15. Mbewu, "Antiretroviral Therapy Is Only Part of It," p. 1152. Lacking lab equipment to per-

form CD4 counts and viral load tests in 2001, PIH's Haitian clinics had substituted a decision algorithm; hence Mbewu's recommendation.

16. Feachem, "HAART—The Need for Strategically Focused Investments," pp. 1152–53.

17. Gilks, AbouZahr, and Türmen, "HAART in Haiti—Evidence Needed," pp. 1154–55. One is reminded of Feachem's concern that "the best not be made the enemy of the good."

18. Farmer, Nizeye, et al., "Structural Violence and Clinical Medicine" (chapter 18 in this volume).

19. See World Health Organization, *Scaling Up Antiretroviral Therapy in Resource-Limited Settings;* World Health Organization, *Towards Universal Access,* pp. 16–18; Benkimoun, "Contre le sida, 'on peut soulever des montagnes.'"

20. In Haiti, Jean-Bertrand Aristide's presidency was abruptly terminated by U.S. intervention in February 2004, and membership in his Lavalas party became grounds for suspicion in the eyes of the new government and the occupying United Nations forces. Many PIH associates with a Lavalas background were killed, driven into hiding, or exiled. In Uganda, money for AIDS "prevention" was sidetracked into abstinence campaigns, which had predictably low efficacy.

21. Farmer, Léandre, Mukherjee, Claude, et al., "Community-Based Approaches to HIV Treatment in Resource-Poor Settings," p. 404.

22. Ibid., p. 408.

23. Ibid., p. 407; cf. Kidder, *Mountains Beyond Mountains,* pp. 242–43.

24. Farmer's lecture "An Anthropology of Structural Violence" (chapter 17 in this volume) was followed in the original publication by comments calling for a more precise and less unwieldy definition of the concept; see Bourgois et al., "Commentary on Farmer, Paul, 'An Anthropology of Structural Violence.'" Loïc Wacquant's critique is the most pointed of the lot: for him, the term "structural violence" "diffuses responsibility in order to expand its ambit," "conflates full-fledged domination with mere social disparity and then collapses forms of violence that need to be differentiated," and finally "is saturated with moral judgments that invite anachronism" (p. 322).

25. Dostoevsky, *Crime and Punishment,* p. 50. The translators (p. 555) suggest Adolphe Quételet as the source of the character's ideas about statistical regularity in human behavior. On incidental characters in fiction, see Woloch, *The One vs. the Many.*

26. Dostoevsky, *Crime and Punishment,* p. 65. The speaker is "a student [Raskolnikov] did not know or remember at all," but his words express "*exactly the same thoughts* [that] had just been conceived in [Raskolnikov's] own head" (pp. 63, 66). Even thoughts and words, it seems, occur with statistical regularity.

27. For another rumination about the uselessness of "simplicity" and "the straight-line approach" in contemplating matters of life and death, see Dostoevsky, *A Writer's Diary,* vol. 1, pp. 641–56, 721–29.

28. See Farmer, "Never Again? Reflections on Human Values and Human Rights" (chapter 23 in this volume) for a discussion of the costs of prevention versus care.

29. This example is taken from Farmer, "Rethinking 'Emerging Infectious Diseases,'" in Farmer, *Infections and Inequalities,* pp. 37–58 (also included in this volume as chapter 6). Once more, note the pattern in which a disease for which subpar hospital care—an effect of international inequality—is partially to blame nonetheless is characterized in the press as emerging from, and poetically belonging to, the Third World population it devours.

30. See Farmer, "The Major Infectious Diseases of the World—To Treat or Not to Treat?" (chapter 12 in this volume).

31. Farmer, "Managerial Successes, Clinical Failures."

32. Kidder, *Mountains Beyond Mountains,* p. 270.

33. Ibid., p. 279. For Farmer's response to Kidder's questions about the "futility" of the episode, see pp. 287–91.

34. Ibid., p. 264.

35. See Dostoevsky, *A Writer's Diary,* vol. 1, p. 735: "The awareness of one's own utter inability to assist or bring any aid or relief at all to suffering humanity, coupled with one's complete conviction of the existence of that suffering, can even transform the love for humanity in your heart to hatred for humanity." In *Pathologies of Power* (pp. 196–212, esp. pp. 204–5), Farmer elaborates on the divide between the medical ethics usually taught in hospitals, centered around end-of-life care and the "quandary ethics of individual patients," and the often unaddressed ethical problem of massive denial of care.

36. *Oxford English Dictionary (OED),* s.v. "viability."

37. To quote the examples given by the *OED:* "Such narrowing or deformity of the female pelvis . . . as will absolutely preclude the birth of a *viable* child"; "I have repeatedly been astonished at the *viability* of the infant after traction had been applied to it"; "He also had some doubts about the *viability* of the work financially"; "They are a main factor in giving [the country] such economic *viability* as it possesses"; "The Russian nuclear capacity appears to be not capable of destroying anything like enough of the American potential for a Russian first strike to be a *viable* proposition"; "[Jordan] was not in economic terms a *viable* state without British support."

38. See Fuller, *Operating Manual for Spaceship Earth.* The word "sustainability" seems to have come into widespread use following the 1987 United Nations report *Our Common Future,* from the World Commission on Environment and Development, a document that is rife with Fullerisms.

39. *Trésor de la langue française (TLF),* 1994, s.vv. "*viable,*" "*viabilité*"; *Grand Larousse,* 1978, s.vv.

40. Castiglione, *The Book of the Courtier,* p. 219 (slightly modified).

41. See *TLF,* s.v. "*vivace*" (1).

42. For an application to paternity, see Frain, *Arrests du Parlement de Bretagne,* pp. 229–30. On the criteria for considering a child "*vitalis*" (equivalent to French *viable*), see Zacchia, *Quaestiones medico-legales,* pp. 47–49. For a discussion, see Fischer-Homberger, *Medezin vor Gericht,* p. 246.

43. Duranton, *Cours de droit français,* vol. 6, p. 92, citing Justinian, "De verborum significatione," *Digests* 50.16.129.

44. In U.S. law, the "threshold of viability" at twenty weeks is held to mark the beginning of the state's interest in protecting the child as a person; for the perhaps least controversial part of a controversial case, see *Roe v. Wade,* 410 US 113, at 163 (1973).

45. Dubrac, *Traité de jurisprudence médicale et pharmaceutique,* pp. 38–39.

46. "Those are not considered 'children' who are procreated contrary to the form of the human race, as when a woman gives birth to something monstrous or prodigious. But a birth that accomplishes the purposes of the human body shall in other respects be considered effective and thus be numbered among the children [of a man]" (Justinian, "De statu hominum," *Digests* 1.5.14; cited as well by Duranton, *Cours de droit français,* vol. 6, p. 95).

47. On "bare life," see Agamben, *Homo Sacer.*

48. Citations from *TLF* and *Grand Larousse,* s.v. "*viable.*"

49. Kidder, *Mountains Beyond Mountains,* p. 19.

PART 1

Ethnography, History, Political Economy

This page intentionally left blank

Introduction to Part 1

Paul Farmer

In rereading the studies and essays collected in this book—some of them published while I was still in graduate school, some of them quite recent and published here for the first time, the majority from the years in between—I discern trends different from the ones I had expected, even hoped for. After more than two decades of writing for peers in anthropology and medicine, one hopes to be impressed by (or at least to note) a steady improvement in the quality of writing, or by ever more thorough exploration of the implications of findings, or by the depths of one's insights. Do these chapters confirm progress? I hope any reader can observe, beyond the shifts of genre, discipline, and audience, the accretion of knowledge and experience that comes with simply sticking with certain topics for many years. I've tried to do that as both a physician and an anthropologist. When speaking to students, I can extol the advantages conferred by identifying important topics early on and sticking with them for a decade or two. I was lucky enough to happen on medical anthropology as an undergraduate biochemistry major bound for medical school, and this discovery has shaped my views on all the key topics reviewed in this book. At least, nearly a quarter-century of attention to a single set of topics should make one more credible as a student of (or spokesperson for) them.

It's less obvious that the results of academic inquiry, when not linked to substantive programs, have much impact on the topics explored. I prefaced the second edition of another book, *Infections and Inequalities,* with an essay finished on July 11, 2000. One of the topics discussed in that book, and this one, was the overweening role of "cost-effectiveness analyses" in determining what constitutes a worthy investment in health and what does not. In that essay, I was not seeking to impugn the logics that underpin cost-effectiveness analyses, but was rather seeking to offer a positivist critique of them by underlining, as a physician-anthropologist might, all the considerations (whether framed in monetary terms or not) that might make such analyses more sound. Writing on the way to attend an international AIDS conference in Durban, South Africa, I conveyed my hope that the book "might serve a pragmatic end by calling into question these and other logics that promise a future in which health equity will play a shrinking role. Only by struggling for higher standards for the destitute sick will we avoid another unappealing role—that of academic Cassandras who prophesy the coming plagues, but do little to avert them."[1]

Looking back now over two decades of writing, I am forced to wonder whether I have succeeded in avoiding the unappealing role of academic Cassandra. Students who find this reader helpful can trace the roots of these essays and studies and decide for themselves. Writing these brief introductions between Rwanda and Haiti and Harvard, I am not sure I can pin down my role, but I am happy to report some improvements since the somewhat discouraged preface to *Infections and Inequalities.* Since that time, we've seen an enormous boom in programs to promote global health equity. New funding mechanisms have arisen to support AIDS treatment programs, flourishing in the very settings in which they were so recently deemed not cost-effective. These new resources and programs have strengthened health systems broadly and allowed us to expand our work from Haiti and Peru and other places mentioned in these chapters to Africa, which has been a great privilege.

We'd like to think that documenting some early work in Haiti has been helpful in this expansion of life-saving medical care. But there are other reasons to write. Biosocially complex phenomena such as the epidemics and the human rights debates discussed here are hard to understand, and descriptions of them sometimes meet with resistance. In order to demystify the process of comprehension, I have encouraged students to try to write about complexity, in the hope (often rewarded) that illumination will follow. "I think with my hands" is the way I've tried to convey my own enthusiasm for writing to my students, most of them physicians-in-training.

George Orwell once wrote an essay called "Why I Write," and it's been helpful to me in contemplating this reader. Orwell enumerates four motives for writing: "sheer egoism," "aesthetic enthusiasm," "historical impulse" ("desire to see things as they are, to find out true facts and store them up for the use of posterity"), and "political impulse" ("desire to push the world in a certain direction, to alter other people's idea of the kind of society they should strive after").[2] I hope that the material published here is seen as falling under the latter two rubrics—that, and simply trying to figure things out. Physicians spend more time taking care of patients than writing, but anthropologists spend much of their time writing;

and for practitioners of the latter field, there's no shortage of angst about *how* we write. Clifford Geertz has examined anthropologists' obsession with "being there" and has argued that many of the conventions of anthropological writing—from the created tense, "the ethnographic present," to frequent recourse to local terminology, explained or translated parenthetically—are to be understood as efforts to show what might be termed, in modern parlance, the ethnographer's street cred.[3] Or, to use a Haitian expression, which will not appear here in the original, "you have to know there to go there."

I bought into this way of seeing the world as I devoured everything ever written about Haiti. It's a wonderful privilege to be awarded a doctoral degree for learning a language, obsessing about a culture, and reading anything one can find about the people and place in question. When I say "bought into," I am not suggesting that I now reject this rite of passage (ethnographic fieldwork followed by writing for one's peers). What I do hope is that my writings about other places I know less intimately—Russian prisons, Peruvian shantytowns, Rwandan settlements, or Guatemalan villages haunted by violence—are also illuminated by the instruction I received both from my professors (at Duke and Harvard) and from my first informants (in rural Haiti). Certainly, the many people cited in these pages have been my teachers in the best sense of the word, and I am grateful to them all. Classroom and clinic and fieldwork have taught me about social process and theory. If there is any unifying thesis here, it's that poverty, gender inequality, and racism—products of the heavy hand of history—powerfully constrain human agency. A decade ago I wrote, somewhat defensively perhaps, that "striving to understand a commonality of constraint is hardly tantamount to denying the salience of personal experience."[4]

Another thing I notice in this reader, which moves from research on epidemic diseases in poor places to essays about poverty and rights more generally, is the heightened affective tone of the later essays. The reason for this is not some temporal evolution in my writing or in the subjects that move me to conduct research and write; my subjects have remained constant since even before my first trip to Haiti, prior to medical school. What has changed is an ability to work more of these sentiments into my published work in journals and edited volumes. The strictures on such writing can be tight and reflect the priorities of the journals or volume editors as much as or more than the topic at hand. (I've been lucky enough to publish my own books, including three others with the University of California Press, in more or less the register I sought.)

For example, one study reprinted here was first published in *American Ethnologist* in 1988. Two years shy of either an MD or a PhD, I was proud of this piece, which I edited several times (along with Haun Saussy), trying to emulate the tone of that journal, prestigious among the few who read it. The research was based on fairly straightforward participant-observation, informed by many interviews, all duly recorded and transcribed and translated. It took two years to research and write just this one paper about a fairly obscure "culture-bound disorder" that afflicted certain nursing mothers in rural Haiti, and the text, as published and in keeping with conventions in anthropology, was replete with words in Haitian and their glosses. I was at the stage of having to prove my seriousness, and so I did, with documentation, methodology, and rewriting.

But early in the course of my youthful enthusiasm for research in rural Haiti, I was brought up short a number of times by my informants, as the jargon goes. Some of them wanted to know why I was spending so much time interviewing young women and herbalists and other local practitioners, rather than spending all my time improving the small clinic we had just built in the squatter settlement where I lived and worked (and where, almost twenty-five years later, I am writing these words). But how to insert the informants' reproach into a scholarly journal without offending the sensibilities of its potential readers, who at the time loomed large in my imagination as a pool of scholarly judges who desperately needed to read my work, whether they knew it or not? (The pool, it turned out, was rather smaller than I believed.) In the end, I decided to include at least one of the sharper rebukes, from a woman I called Mme. Gracia. Along with thousands of others, she had been flooded out of a fertile valley by a hydroelectric dam and was now living in a dusty squatter settlement. I must have recorded her remarks in 1986 and written them up in 1987 for publication in 1988. Hers was the final word:

> Mme. Gracia, a woman in her late sixties, insisted that I not forget recent history. She reminded me to attend to the larger context in which "malignant emotions" arose: "*Move san* is not something that was regularly seen before [the valley was flooded]. Some people died from it after the dam was finished. Now we are up here and we are poor. We have no livestock, no [sugarcane] mills. We suffer too many shocks (*sezisman*), too many problems. We are poor and we are weak, and that is why you see *move san*."

Mme. Gracia was among those who chided me gently for paying attention to issues that were less pressing than the need for water, health care, and education. That was it for me. I knew Mme. Gracia was right.

Thanks to undergraduate studies, to graduate school, and to Haiti, I had a good sense for what sort of anthropology I wanted to pursue. Shortly before I began my first year as an official MD-PhD student, I read a book by George Marcus and Michael Fischer about the state of anthropology: they noted that "an interpretive anthropology fully accountable to its historical and political-economy implications thus remains to be written."[5] That was precisely what I wanted to do and write, and the name of part 1 of this reader reflects this ambition. I wanted to link "experience-near" writing to an understanding of the larger structural underpinnings of lived experience in the places where I work. Haitians, after all, told me again and again that it was their poverty that led or pushed them into this or that catastrophe. I could see that they were right—but what, as my teachers often asked, was the theoretical underpinning of such work?

The obsession with "contributing to theory" saturated not only seminars but also discussions among graduate students. (Such discussions did not occur over at the medical school, where the task at hand was cramming what was termed "factual information" into one's head as fast as possible.) In graduate studies, it was all about theory—the more recondite, the better. There was, in the books we were reading at unsafe speeds, a good deal of distance, not to say a divorce, between what passed for empirical data, the fruit of ethnographic fieldwork, and the theoretical scaffolding on which this data, frequently in light doses, was hung. Also common, in the social sciences in general, was the feat of linking ethnographic information to one theory about society when the same information might as well have been advanced as support for another, completely discrepant theory. That was not the sort of anthropology I wanted to write.

The Haitians were training me to be skeptical about claims of causality (even as they advanced their own claims with great assurance), and I knew, before I embarked on graduate studies, that I wanted to be a practicing physician and—to the initial disappointment of some of my teachers—an activist. But an excellent course in social theory, reaching back to Comte, Weber, and Marx, while paying respect to Frantz Fanon (this respect moved me deeply) en route to Habermas and other luminaries, convinced me that there was more than enough social theory to go around. In addition to being influenced by my Harvard mentors, I was drawn to the work of Sidney Mintz, for he had built up an interpretive anthropology accountable to history and political economy—even if a lot of the interpretive stuff was buried in obscure papers about Haitian market women or in riveting life histories. At the same time that I was writing "Bad Blood, Spoiled Milk," which was based on ethnography, I was trying to write another paper about Haiti's history and political economy. The two papers were published simultaneously, the latter in a Marxist anthropology journal. (Perhaps the words of one of my mentors still reverberate in my memory—"Sure, they'll publish it, as long as you follow the party line"—since I did not object when Haun Saussy left the essay out of this reader.)[6]

Thanks to medical school and, especially, to Haiti, I also had a good sense of the kind of medicine I wanted to practice: infectious disease. The plagues I was seeing were both preventable and curable, I thought, as I turned reluctantly away from general surgery, another field that tempted me when I witnessed what the Haitians called "stupid deaths" from obstructed labor, gunshot wounds, injuries from falling rocks or machetes, and peritonitis. By 1988, Haiti and Haitians had steered me in certain directions within both anthropology and medicine. I was and am grateful for it. Surrounded by epidemic disease, I decided that I would both study epidemics and do my best, working with others, to stop them or at least lessen the suffering caused by them.

NOTES

1. Farmer, *Infections and Inequalities,* p. xxviii.

2. Orwell, "Why I Write," in Orwell, *The Collected Essays, Journalism, and Letters of George Orwell,* vol. 4, p. 2.

3. See Clifford Geertz's essay "Being There," in Geertz, *Works and Lives,* pp. 1–24.

4. Farmer, *Infections and Inequalities,* p. xli.

5. Marcus and Fischer, *Anthropology as Cultural Critique,* p. 86.

6. Farmer, "Blood, Sweat, and Baseballs." The argument of this essay is further developed in Farmer, *The Uses of Haiti.*

1

Bad Blood, Spoiled Milk

Bodily Fluids as Moral Barometers in Rural Haiti

(1988)

Current discourse in medical anthropology is marked by an increasing appreciation of the body as physical, social, and political artifact. Concepts such as somatization, which implies the making corporeal of nonbodily experience, are by now common coin, and there is considerable enthusiasm for the increasingly fine-grained analyses that appear in several new specialty journals. But others discern an overweening analytic urge that yields fragmentary knowledge resistant to synthesis. Illness experiences are picked apart under the dissecting gaze not only of biomedicine but of anthropology as well, a discipline long parsed into such officially sanctioned subfields as "psychological" and "biological" anthropologies. Appreciating the full weight of centuries of what has come to be called Cartesian dualism, Nancy Scheper-Hughes and Margaret Lock write forcefully of our "failure to conceptualize a 'mindful' causation of somatic states."[1] How might we gather up our fragmentary knowledge? Several of those seeking to reconcile the three bodies have turned, in the past few years, to emotion.

An illness widespread in rural Haiti speaks to this and several other dilemmas central to contemporary medical anthropology. To use the tropes now common in our field, *move san* is somatically experienced and caused by emotional distress. *Move san*—for which a literal English equivalent is "bad blood"—begins, report my informants, as a disorder of the blood. But it may rapidly spread throughout the body, so that the head, limbs, eyes, skin, and uterus may all be affected. It most frequently strikes adult women; some assert that only women are afflicted. Although considered pathological, *move san* is not an uncommon response to emotional upsets. The disorder is seen as requiring treatment, and this is commonly effected by locally prepared herbal medicines.

The course and outcome of this illness, if it is untreated or unsuccessfully treated, are reported to be dismal: several of my informants speak of friends and relatives who have succumbed to *move san.* Those most vulnerable are pregnant women or nursing mothers; in such cases, chances are good that the malady will affect the quality of breast milk. *Move san* is the chief—and some say the only—cause of the *lèt gate,* or spoiled milk, syndrome: "bad blood" is held to make it impossible for a lactating mother to afford her infant "good milk." It is thus a frequently cited motive for early weaning, which, in rural Haiti, often has disastrous effects on the infant's health. The chief effects of *move san,* however, are judged to be manifest in the mother.

Although I first encountered the *move san/lèt gate* complex in 1984 while doing research on childrearing in peasant families, its significance as a perceived threat to health was not clear until research conducted during a 1985 census revealed a 77 percent lifetime prevalence rate of *move san* (with or without *lèt gate*) in Do Kay, a small village in central Haiti and the site of most of the research reported here.

Move san has not been systematically studied, nor have thorough case studies been presented in the anthropological literature on Haiti.[2] The disorder is of interest to medical (and psychological) anthropology for several reasons, many of them obvious. Those who suffer from *move san/lèt gate* cite it as a danger to the health of women already beset with intractable and unrelenting difficulties. Child health specialists from several traditions would maintain that *move san,* like all other motives for early weaning, constitutes a threat to the health of infants. The disorder joins a long and varied list of conditions in which women question their ability to breastfeed.[3] But *move san* and *lèt gate* are more than ethnographic exotica or public health nuisances. The significance of the syndrome lies in the fact that social problems and their psychological sequelae usually are designated as the causes of the somatically experienced disorder. For this reason, the Haitian syndrome poses a challenge to overly simplistic interpretations of "folk illnesses."

Following the suggestion of others who advise that indigenous illness categories first be studied "emically," from within their cultural context, I will consider the *move san/lèt gate* complex to be an illness caused by malignant emotions—anger born of interpersonal strife, shock, grief, chronic worry, and other affects perceived as potentially harmful. It is thus not possible to relegate *move san* to such categories as "psychological" or "somatic." This stance, which avoids the strictures of a dogmatically "medicalized" anthropology, is reconsidered in the conclusions offered at the end of the paper.

THE RESEARCH SETTING

The Republic of Haiti occupies the western third of the island of Hispaniola. After the Dominican Republic, which borders it to the east, its nearest neighbors are Jamaica to the southwest and Cuba to the north and west. Haiti, born of a slave revolt that ended in 1804, is the hemisphere's second-oldest independent nation. Its inhabitants are largely the descendants of the African slaves that made western Hispaniola France's most lucrative colony. During the nineteenth century, the nascent peasantry, left to its own devices, developed richly syncretic linguistic, religious, and ethnomedical institutions. In 1982, Haiti's population was conservatively estimated to be 5.1 million, or 345 persons per exploitable square kilometer. Despite the alarming density, 57 percent of the labor force is involved in small-scale agriculture. Some 74 percent of the country's inhabitants are rural; many live in villages similar to the one described in this study. Estimates of per capita income usually put Haiti last among the countries of the Western Hemisphere, and this poverty is reflected in the health status of the nation: a life expectancy of forty-eight years and an infant mortality rate of 124 per 1,000.[4]

Do Kay stretches along an unpaved road that cuts through Haiti's Central Plateau. A small village in great flux, it has been the locus of almost all "development" efforts in the area. Consisting of 123 households in 1985, Do Kay had a total population of 677. Exactly one year later, a census by the same team revealed 11 new households, bringing the number of inhabitants to 772. Some of the increase in population is due, it seems, to the construction, since 1980, of a church, a school, a clinic, and a community bakery and the initiation of a project to make pigs available to the rural poor.

The area has a curious and ironic history. Before 1956, there was no Do Kay; the village of Kay was situated in the fertile valley of the nation's largest river. A great many of the persons now living in Do Kay then lived in an area adjacent to Kay called Petit Fond. When the valley was flooded to build a hydroelectric dam, the majority of villagers were forced to move up into the hills on either side of the valley. Kay became divided into "Do" (those that resettled on the stony backs of the hills) and "Ba" (those that remained down near the new waterline). Most villagers received no compensation for their land, nor were they provided with water or electricity. For many, the years following the inundation of their lands were bitter. As deforestation and erosion whittled away at the hills, it became more and more difficult to wrest sustenance from them. And yet Do Kay is typical of many small Haitian villages in which the great majority make a living by tending small gardens and selling much of their produce. Marketing is largely the province of young to middle-aged women, many of whom are also responsible for growing their merchandise.

The majority of the houses comprise two rooms: a *sal* with chairs, and a *cham* with straw mats or, occasionally, a bed. Although average household size in Do Kay is between five and six persons, it is not unusual to find more than ten sharing these two rooms. Typically, dwellings are constructed of stones covered with a cement-like mud, although wattle daubed with mud is not uncommon. There is still no electricity in the area, and none of the houses has running water.

Until recently, for their water supply, residents of Do Kay were forced to scramble down a steep hillside to a large spring 800 vertical feet below the level of the road. Although villagers seemed to know the dangers of drinking impure water, the temptation was to store water in large pots or calabash gourds. Infant deaths due to diarrheal disease were commonplace. A hydraulic pump now moves springwater up to three public fountains placed along the road and also to the school and other buildings run by the church.

There is no village center or "square," although the school-church-clinic complex may be beginning to take on this function. The clinic was inaugurated in 1985 and began offering consultations with a Haitian doctor two days per week. Until March of that year, when the bakery opened, there were no retail shops or businesses, though a few commodities (canned milk, local colas, small quantities of grain) could be obtained from the handful of families known to "resell."

Excluding the doctor, all the informants cited in this research were born and grew up in rural and agrarian Haiti. They are all, by their own criteria, extremely poor. This brief introduction is intended to situate the *move san/lèt gate* syndrome, primarily an affliction of women, against the background of the daily struggles of the remarkable women of Do Kay.

INTERVIEWING METHODS, CASE-FINDING, AND SURVEY RESULTS

The research on which this paper is based was conducted as part of a larger study of childrearing and nutrition in rural Haiti. When the study was initiated in 1985, I restricted in-depth interviewing to Do Kay. I had already lived in the village for over a year and knew many of its inhabitants. Other researchers working in Haiti have found familiarity with informants to be crucial to obtaining reliable data.[5] Initial interviews indicated the modal weaning age to be eighteen months, and so I decided to interview the mothers or primary caretakers of all children eighteen months and younger. By September 1985, there were forty-seven such infants in Do Kay. Interviews with mothers were preceded by three lengthy "pretest" interviews with tried-and-true informants (such as Mme. Kado,[6] introduced later) who had helped me in the past. Most mothers (or primary caretakers) were interviewed, in their homes, more than once in 1985.

Although the interviews were open-ended and followed no rigid format, several issues were always addressed. Among these were *move san* and its relation to breastfeeding. As the significance of the disorder became manifest, I devoted more interview time to its characterization. Among my informants were three women who claimed to be experiencing *move san* at the time of the initial interview. These were considered "active cases." Two of the three were attempting to breastfeed infants; these women were interviewed several times over twenty months.

For purposes of this preliminary discussion, it is necessary to indicate that a startlingly high percentage (thirty-six mothers, or 77 percent) of those interviewed had experienced at least one identifiable episode of *move san.*[7] Thirty-two of the thirty-six, or 89 percent, sought treatment in the professional or popular health sectors: three went to a biomedical practitioner; thirteen consulted only a *dokte fey* or other herbalist; sixteen sought treatment from more than one source (although recourse to an herbalist was almost always included in the quest for therapy). In the majority of cases, professional care was preceded and then supplemented by home health care.

The central problematic of this paper is not, however, *move san* as an isolated disorder, but rather the *move san/lèt gate* complex. Of the thirty-six women who had experienced at least one episode of *move san,* seventeen, or 47 percent, stated that they had been breastfeeding an infant during an episode. (Of the three women who remarked that they felt that their lives had been in danger, two were among this group.) Of the seventeen, fifteen sought treatment outside the home for (or, in two cases, to prevent) *lèt gate.* One woman who had not sought treatment outside the home was one of the three respondents who had *move san/lèt gate* at the time of the 1985 survey; she was gathering the funds necessary to defray her treatment expenses. The other respondent was treated effectively at home, by her mother's sister. Ten of the treatment regimens for *move san/lèt gate* met with success; these women declared that they had been "cured" by the remedies. The remaining six all weaned their children, citing *lèt gate* as the motive; only two of these six children were normal weight for age by the Gomez scale, a widely used measure of childhood malnutrition.

In all cases, the etiology of the *lèt gate* was held to be *move san;* in other words, their association, which was guaranteed by the methodology, was never labeled as chance by an informant.[8] The etiology of *move san* itself was invariably seen to be a malignant emotion, most commonly caused by interpersonal strife. Of the thirty-six informants with a history of *move san,* twenty-four cited such strife as the cause of the disorder. Seventeen of these conflicts involved a spouse, partner, or family member (in descending order of importance: husband or mate, brothers and sisters, parents and children); five involved *vwasinay,* or neighbors; and two involved near or total strangers. Of the remaining twelve informants with a history of *move san*, there were five related cases of shock (*sezisman*), and the other seven adduced a mixed bag of stressors, most related to chronic financial problems (for example, shame at being unable to feed children), all of which had led to “too much bad emotion.” Distinctions between personal and social stressors seem significant, but I have not yet discerned any clear pattern of course or outcome that might be related to such differentiation. No clear symptomatology for *move san* emerged from the preliminary readings of the interviews.

CASE HISTORIES

Given that *move san* is a common problem among the mothers of children under eighteen months of age in Do Kay, what is the natural history of the illness? What are the psychological concomitants of “bad blood”? Who is at risk? How long does it last? What are its symptoms? How is it treated? Why do some women find successful therapy, while others do not? These were among the questions that led me to elicit more psychologically detailed case histories from the three women afflicted with *move san* at the time this study was initiated. Because I knew little about the perceived course of the illness, it seemed imperative to follow the cases over long periods of time. Two of these histories are presented here, the first in detail because it is a good example of the common scenario in which the label *move san* is invoked. It is also prototypical[9] in that it illustrates what appears to be the classical course of the disorder. The second case is one in which the *move san/lèt gate* syndrome was caused by “shock” (*sezisman*) or fright; though far less frequently invoked as precipitating the disorder, it was the second most common etiology given by my informants.

Case 1

Ti Malou Joseph, thirty years old, has had recurrent episodes of *move san;* each has been precipitated, she readily avers, by discord with the father of her children. She and her living children brought to a total of thirteen the number of persons sharing her parents’ two-room house. Although I have only indirect indicators of socioeconomic status, the Joseph family is considered one of the poorest in the village. The house is roofed with tin, but the floor is tamped dirt. Both of her parents are frequently ill, and Ti Malou and a younger sister are usually the major breadwinners for the family. To generate income, they engage in small-scale gardening and the buying and reselling of produce and staples such as raw sugar. Often, Ti Malou lacks the (very small amount of) capital necessary to participate in the rural marketing network. Currently estranged from the father of her children, she is emblematic of the uncounted Haitian women who labor against increasingly dismal odds.

Ti Malou was interviewed several times. The first session took place late in the sixth month of her fourth pregnancy. When asked if she had ever suffered from *move san,* she replied that she had, asserting that she was experiencing it at that very moment. (Another informant, Mme. Kado, had hinted that I would find an active case in Ti Malou.) When asked to describe "the problem," she explained, "I think the problem is the result of fighting with the father of my children. He hit me, a pregnant woman, and made life very difficult for me." Several months after the birth of her child, and two months after being cured, Ti Malou had not significantly changed her ideas about etiology:

> If you're having troubles (*nan kont*) with someone, and they yell at you or strike you, you can become ill. My illness is the result of fighting with the father of my children. He struck me while I was pregnant and rendered my life very difficult. He struck me in the face. That's what makes the blood rise up to my head and spoil the milk; this happened during my fifth month, and by five and a half months, my *move san* had already erupted [in *bouton,* small, raised blemishes] all over my body. The blood mixes with the milk; if it reaches the uterus, it will kill you rapidly.

As her pregnancy progressed, Ti Malou became more and more uncomfortable. She complained of severe lower-back pains (*doulè senti*), muscle cramps, headaches, dizziness, light-headedness (*soulay*), diarrhea, and crampy stomach pain. She endured a month or so of these symptoms, seeking no care outside the home or family friends. By the end of her seventh month, she was "unable to get out of bed." In early July, she began experiencing tingling and then "numbness" in her legs. She fell one day "because I had no sensation in my left leg." In mid-July, a full month before her expected date of confinement, she began experiencing what she described as "labor pains":

> It wasn't my time, but something was happening. I thought they were labor pains (*tranche*). I began to worry about the fall (*sò*) I had taken. Madame Kado told me that I was carrying twins, and that one of them had been damaged when I fell. I suspect now that it was not the fall that was responsible for the death of one of them. That might have left a mark on the child, but it wasn't severe enough to kill her. I went to see the doctor [in Mirebalais, a nearby town], but he said that there was nothing wrong, and that the baby wasn't due yet. He didn't think there were twins.

Mme. Kado, an influential friend, had informed Ti Malou that her symptoms were "in large measure" due to *move san;* by the end of the pregnancy, her mother and other family members agreed. Herbal remedies, the therapy of choice, were interdicted during the pregnancy, because "the medicine is too strong for the baby." During her final month of pregnancy, Ti Malou was in bed more often than not. Everyone agreed that she looked ill; more than one member of her family remarked that she was "as white as a person with tuberculosis."

When labor pains did begin, it was decided that she should go to the hospital to deliver rather than having the usual home birth attended by a midwife. There were bound to be complications, according to Mme. Kado. Late one evening, about a week after her "date," Ti Malou and her mother left for the hospital in Hinche, about an hour away. They paid for a space on one of the trucks that carries produce and its vendors from the Central Plateau to Port-au-Prince and back again.

Rumors drifted back to Do Kay throughout the next day, with many versions of the story of her labor and delivery. All agreed, however, that the process was bedeviled from the start. One of Ti Malou's younger brothers followed them the next morning; he returned that evening, bearing bad news. His sister was "bleeding," he said, and needed a transfusion. This she would not receive without prepayment. The news was greeted by Mme. Kado and other friends (myself included) with horror. The requisite fifteen dollars (more than a month's income for many rural families) was collected in short order and dispatched with a kinswoman of Ti Malou. The next day we heard nothing. Mme. Kado feared the worst and suggested that *move san* was also to blame for Ti Malou's complications. On the third day of her hospitalization, Ti Malou gave birth to twins: one, Jules, was alive and well; the other was stillborn.

Her subsequent case of *lèt gate* was seen both as a confirmation of the *move san* diagnosis, if anyone doubted it, and as a further indication of the severity of the episode. Most of her symptoms persisted, but she delayed a trip to the *dokte fey,* or herbalist, citing financial worries. Ti Malou's father prepared a root-and-leaf concoction, but her relief was short-lived. The family became concerned that her breast milk would "pass" into her head and make her "crazy" or kill her. (No one in the Joseph family other than Ti Malou mentioned the uterus.) Three weeks after Jules's birth, he too broke out in *bouton.* He grew listless and stopped gaining weight.

Mme. Kado and others indicated that it was "scandalous" that Ti Malou had not yet attended to "their" illness properly. Mme. Kado recommended a midwife about an hour's donkey ride from Do Kay; she was reputed to be adept at curing *move san/lèt gate.* Her rates were more reasonable than those of a *dokte fey,* but her results were as good. Finally, Ti Malou did go in search of the indicated root-and-leaf remedy. (Such an interaction is depicted by the midwife later in this study; see "The Healer's EM.") Ti Malou also made a second visit to the doctor while she was a *ti nouris,* as a mother is known for the first several weeks of nursing. Although the visit was only a few days before her trip to see the midwife, she again did not mention her disorder to the doctor. Her chief complaint, he reported, was a fungal infection in the infant's throat.

Case 2

Alourdes Surpris is the twenty-three-year-old mother of one of the most malnourished children in the village. At eleven months, her daughter Acephie weighed 5.7 kilograms; by the Gomez scale, she suffered from third-degree malnutrition. Although at the time of this writing Acephie is less malnourished, developmental delays are evident. Surprisingly, the child would seem to be one of those least at risk of nutritional disease: she lives with both parents in a three-room house directly across the street from the school. Her father is a schoolteacher and nets a small, but regular salary; Alourdes works in the new day care center and has received several years of formal education. Although the couple was not married when the child, their first, was conceived, both reported wanting a child very much.

How did this unlikely candidate become malnourished? The cause was probably early weaning: "I weaned her at five months. When she was born, I breastfed her, but my milk dried up; I had to wean her right away." Alourdes's notion of why her milk "dried up" is quite specific:

> I have had *move san* ever since a bolt of lightning struck my house and narrowly missed killing my husband and child. . . . It knocked us right out of bed. I was shocked (*sezi*) so much that I could never breastfeed again. I couldn't concentrate, I couldn't fall asleep. Whenever the baby cried, I'd jump. My heart was skipping. Even though I took a great deal of [herbal] medicine, my milk was never restored.

As noted earlier, five of the seventeen cases of *lèt gate* due to *move san* were caused by *sezisman*. Although further study is clearly necessary, it seems as if the course of *move san* is similar regardless of the source of the malignant emotion perceived to have caused it (for example, interpersonal strife, economic pressures, natural cataclysms). The healer I interviewed remarked that minor changes in the remedy are called for if the *move san* is caused by shock, though not all informants made such fine distinctions.

MOVE SAN/LÈT GATE AS "INTERPRETED DISORDER"

In a critique of methodologies grounded in an "empiricist theory of language," Byron Good and Mary-Jo DelVecchio Good suggest that an analysis of indigenous illness categories should include both an investigation of the sociocultural construction of illness realities and the analysis of the "semantic networks" that link "key public symbols both to primary social values and to powerful personal affects."[10] To put it somewhat differently, a symptom may be thought of as a vehicle of meaning that connects two different kinds of referents—the traditionally expected ones and the unexpected, "private" ones. As the first of several steps in the analysis of the *move san/lèt gate* complex, I will adopt a meaning-centered approach that encompasses both the more psychological as well as the more somatic components of a disorder that defies facile Cartesian classification. My task is not only to describe both shared and idiosyncratic meanings but also to answer some of the key questions listed at the outset: What is the natural history of the illness? How long does it last? What are its symptoms? How is it treated? Why do some women find successful therapy, while others do not? What sorts of emotional upset are most frequently associated with the illness? What triggers these emotions? Who is at risk?

One means by which semantic networks may be evoked—and an understanding of the construction of an illness experience approached—is through eliciting informants' explanatory models, or "EMs," to use the accepted shorthand.[11] Because such an approach takes informants' discourse seriously, it entails literal and liberal quotation. It attaches narrators to narratives and recognizes discourse as context-dependent. Space restrictions limit our discussion to one case, that of Ti Malou. (As a matter of convenience, I often refer to her as "the patient.") Although her case history, presented earlier, pointed out many facets of her EM, we have not examined in detail, much less contrasted, the discourses of the patient, her friends and family, and her healers. Those engaged in the clinical process include at least a confidante (Mme. Kado), the patient's mother, a midwife/healer, and a physician. Each was interviewed at length at least twice during the illness episode.

My analysis is also meant to be mindful of three fundamental charges that have been leveled at interpretive medical anthropology. Much of the material published to date has been narrowly focused on "the doctor/patient relationship." I thank my informants for making it clear that the doctor's EM was far less relevant to their own constructions than were the other EMs presented here. Further, slighting the individual psychological nature of the illness begs the entire question of intracultural variation. Finally, study of EMs too often ignores the fact that they change over time. Not only are explanatory models reformulated and even re-created during the same illness episode; they also may be reshaped in different contexts at the same point in the episode. The cases presented here have been followed over twenty months. Interviews with older women added a greater time depth than my own recent involvement could afford. The concluding section examines in more detail the correctives that a multiply-situated discourse and its inferred connections can bring to interpretive exercises.

The Patient's EM

Ti Malou's EM might be described as "somatosocial." Although she gave the *move san/lèt gate* complex a social etiology, Ti Malou tended to focus discussion of her illness on her shifting symptoms and on the pathophysiology and course of the illness. To cite an interview following her successful cure:

> I've had it before; my life has been full of problems like this. The first thing I noticed was a bumpy rash [*bouton*] that erupted all over my body. After that, I felt terrible; I couldn't sleep, I had no appetite, and I had diarrhea. I tried treating the diarrhea with clinic medicine, but it wasn't until I took the herbal remedy [over three months later] that I was really free of it. I also had a terrible headache, and my jaw was stiff and difficult to move and my mouth was always full of water.

Her selectivity is not to be mistaken for "lack of insight" or reluctance to confront "interpersonal" difficulties: when questioned, she unhesitatingly cited the social and psychological origins of her distress. But in her more unprompted discourse, she tended to dwell on her discomfort and her quest for treatment.

Another aspect of the treatment described most fully by Ti Malou was the necessity of separating blood from milk before therapy could be successfully initiated:

> As soon as the child was born, I knew that the milk was no good. My father went in search of a medicine for me to drink. I did indeed drink it, but it had no effect, because my father did not know to separate the blood from the milk . . . before making me take the remedy. It was the midwife who began by separating blood and milk. Only when this was achieved did she start me on the remedy.

When asked what was wrong with her milk, Ti Malou responded that it had become "weak, watery" and had been "invaded by bad blood." When asked quite pointedly what had caused her blood to go bad, she readily replied, "Emotion" *(emansyon). Move san* and *lèt gate,* it is clear, are embedded in social interactions. As noted, interpersonal strife is designated as the cause of most cases of *move san.* The household *(menaj)* is the context in which the majority of these cases occur. In Do Kay, at least, a woman's husband or lover is not infrequently regarded as a potential agent of discord. So it was with Ti Malou. One striking aspect of the nature of the interaction between Ti Malou (and her friends and family) and the man who is held to have caused "all her problems" is the considerable comity that marks their every public exchange. This important point will be considered more fully later.

The Mother's EM

In 1985, Jesula Joseph thought that she was approaching her fiftieth year, "but I don't pay much attention to things like that." Indeed, more pressing dilemmas crowd her life: thirteen people to feed, more than half of them children; her own considerable health problems, which include deteriorating vision and chronic back pain; her sickly husband's inability to work; a leaky roof and a rainy season; and two sick grandchildren. Ti Malou's illness arose against a backdrop of unremitting struggle. In our first session, conducted a week before I first interviewed her daughter, I thought I detected a resignation that bordered on lack of interest: "I don't know. Sometimes when you're pregnant it's like that. Some women have a harder time bearing children. It's God's will. I don't know. Maybe it is weakness (*feblès*)." Later in the same interview, when asked if she thought her daughter might have *move san,* she expressed doubt: "I think it is a difficult pregnancy, not *move san.*" A month later, she stated that a third-trimester fall had caused many of Ti Malou's problems.

A few days before Ti Malou's confinement, however, her mother was confident that *move san* was at the root of her daughter's symptoms. Mme. Joseph's "lack of interest" dissipated as the family came to perceive Ti Malou's problem as their greatest worry. Mme. Joseph's comments remind us of the need to adopt a more process-oriented approach to the study of illness meanings. Five months and three interviews later, it had become clear to me that her central etiologic interpretations had been revised at least three times during that period. What was at first a difficult pregnancy (later exacerbated by a fall) came to be redefined as *move san,* and finally as the full diapason of *move san/lèt gate* triggered by a malevolent lover. Close attention to the temporal sequence of the revisions, as well as the changes in Ti Malou's EM, led me to believe that the persuasive force of Mme. Joseph's conceptions had been overshadowed by those of Mme. Kado's EM, examined next.

A Confidante's EM

Madame Anita Kado, a fifty-one-year-old widow, is the mother of nine children, seven of whom are living. She is a cook and an aide-de-camp to the priest who runs the school in Do Kay. She considers herself a resident of Mirebalais but has long spent most of her time in Kay. A presence there for over a decade, Mme. Kado now wields considerable influence. As the daughter of a midwife, she has a longstanding interest in health issues. She is clearly a member of what might be described as Ti Malou's health management group.[12] As far as I know, Mme. Kado was the first to suggest that Ti Malou's difficulties were due to *move san.* By the end of the pregnancy, everyone agreed that Ti Malou was suffering from the disorder and that it had to be treated as such.

Mme. Kado, always an excellent informant, had a good deal to say about *move san.* These quotations are from an interview that took place shortly after Ti Malou's effective treatment:

> If you have an argument or a fight with someone, and if [that person] yells at you while you're pregnant, when the child is born, it will have problems. If he doesn't have diarrhea, the sickness will cause *bouton* to erupt all over him. This indicates that the milk is spoiled. The baby will continue to nurse, but the milk isn't good for him and will give him diarrhea. It's necessary to wean the baby temporarily. If nothing is done about it, even the next child will be affected. A remedy is necessary. You must find a person who knows how to make the medicine, and get two or three doses—enough for about four days. The baby needs to start nursing again for the remedy to work properly. You don't have to give the baby any medicine; he'll take it from his mother's breast, it will reach his blood and take away the bad milk he's already consumed. When the diarrhea starts to go away, you know that the milk is starting to get back to normal. If the diarrhea persists, the milk is still spoiled.

I asked her if babies ever died from *lèt gate.*

> No, never. It's the mother who can die. Ti Malou is a good case. If you're not getting along with someone—perhaps you've said something bad to her, and she becomes angry with you or upset and starts to cry, she can have *move san.* With someone like Ti Malou, it was clear that she began to have *move san* after Luc hit her. But for some people, the first sign is after the baby is born, when you see the milk is no good. If the spoiled milk mixes with the mother's blood and then reaches her uterus, she can die. The milk can go to her head and make her crazy; it can even give her diarrhea as it does the child. It begins to dominate her until it gives her a very serious illness. If that happens, she will surely die.

How can one be sure that a baby's *bouton* and diarrhea are caused by *move san?* Mme. Kado's response was characteristically confident and empiric:

> Well, we knew the milk was no good: it was as clear as water. But to make sure, express some of the milk into a large spoon; if it's thick and white, it's probably not spoiled. Take the spoon and hold it over a flame. As it begins to boil, put a small twig in it. If the cream climbs up the stick, the milk is good. If it doesn't make cream, it's no good. But it's usually not necessary to do this.

The worthlessness of "thin" or "watery" milk is a theme that recurs not only in Mme. Kado's discourse but in that of most of my informants. Two women expressed breast milk into a cupped hand to demonstrate the patently inferior quality, in their eyes, of their milk. These adjectives were held in contradistinction to their antonyms: thick versus thin or watery, opaque white versus clear, strong versus weak, healthy versus unhealthy. The oppositions became a leitmotiv that ran through many of the interviews; as the healer's explanations make clear in the following section, they extend analogically from the body physical to the body social.

Opinion was split as to the cause of the stillbirth in Ti Malou's case, but the disorder was widely held to have complicated labor and delivery. Mme. Kado suggested that *move san* had been at the root of the problem:

> The milk begins to build up early in the pregnancy; it is spread throughout the body, like the blood, but must never mix with blood. In the girl's case, not only did the blood and milk mix, which made the milk turn (*tounen*), but I think it may have started to infiltrate the uterus (*lanmè*). This is very dangerous; she's lucky to have escaped. The guy probably did this on purpose.

Although Ti Malou and her mother were willing to state that the problem was *move san* and that *move san* is caused by emotion, they were less willing to discuss in detail the nature of the discord that engendered the malignant sentiment. Mme. Kado, on the other hand, was full of theories:

> Certainly, it may have been only the emotion that turned the milk, and made it leave its place. But when the illness is so bad (*rèd*) that a baby dies, you begin to think that the bad person did more than yell at the woman. It's usually the *woman* who is sick with simple *move san*.

When asked what she intended by her comment, Mme. Kado hinted that Ti Malou's former consort may have tried to "poison" her. Further, Mme. Kado confided that Ti Malou's mother had similar suspicions. (On a subsequent interview of the patient's mother, I found that she had indeed come to believe that her daughter was the victim of maleficence.) When Mme. Kado was asked to fully explain what she meant by "poison," it became clear that she was not speaking of a toxin. She illustrated with a personal scenario:

> I had nine children, and I lost two. With the one who died when she was eleven days old, it seems as if it was a bad person *(move moun)* who did the damage [lit. "tempted it" (the fetus)] while I was still carrying the baby. This person gave me something, but I had no idea: I thought she was my close friend! She cooked for me, I cooked for her . . . she was always over at the house. And then she gives me a bit of *joumon* [a Haitian squash] during the very week that I gave birth. . . . On the seventh day [postpartum], things started going wrong. . . . I thought the baby was uninterested in nursing. She was not yet sick, but she was about to be. When I got up very early the next morning, her jaw was locked shut *(machwa-l te sere)*. . . . When she reached the eleventh day, at four o'clock in the morning—the same time that she fell ill—she died. And when she died, out came the bit of *joumon,* exactly as I had eaten it.

Mme. Kado reports that the "bad person" is still living in Mirebalais. When I asked whether she still spoke to the perpetrator of the crime, she expressed surprise at the question: "Do I still speak with her? Of course! With people like that, you never let on that you know they're no good. If you do reveal that you know how bad they are, you'll never have children."

Mme. Kado's anecdote raises more questions than it answers. Did Mme. Kado have *move san* after this event? "Not really," she replied, "although I did take a leaf-and-root medicine to prevent my illness. I'm not very susceptible." Why not? What factors render Ti Malou more susceptible to the disorder (or Mme. Kado less susceptible), or does the difference reside in the precipitating events? How often does *move san* involve malevolent poisoning or magic poisoning? Mme. Kado felt that "you don't have to have a bad person trying to do something to you to have *move san,* but it happens like that sometimes." Some of these questions will be addressed later in this study.

The Healer's EM

Mme. Victor is known as a midwife who is knowledgeable about herbal remedies; she is not, however, a *dokte fey.* She does not know her age but looks to be at least sixty. She lives several miles from Kay in a very modest two-room house. When I interviewed her there, slightly more than two months after she had seen Ti Malou and cured her, she had just returned from delivering a baby. She remembered Ti Malou's case vividly, although she had met her client only once before the therapy. I did not ask how much she charged to cure Ti Malou, but Mme. Kado had estimated that her fee was about five dollars.

Her notion of etiology was not too different from those detailed earlier, although she contended that *move san* is not exclusively a woman's disorder:

> Anyone can fall ill with *move san;* it happens mostly to women, but it can also happen to men. If you are deceived, cheated, cuckolded, ostracized, or frightened, you must beware of *move san.* It can happen in a short amount of time; within a week you're very ill. The first thing you notice is an eruption of itchy bumps all over your body. Then you might have a headache, fever . . . your mouth becomes dry, you're very jumpy . . . your blood turns into water, and you feel weak or stiff. . . . A person with *move san* can sleep all day long. If you press on your nails, you note that there's no blood under there, and you know then that it's turned. Your eyes also turn white. If you're poor enough, you'll feel that you still have to go work in your garden, but if you let the sun cook your already watery blood, it will make it all worse. You become like a leaf: more and more withered. Soon you don't even look human. . . . If the victim is a nursing mother, the milk's as good as lost; it goes bad. You need the [herbal] remedy to make new milk. As soon as you've finished the first day or so of medicine, you can expect the milk to start coming down beautifully, then the headache will go away, as will the body stiffness.

Mme. Victor's discourse was rich in details, which is not surprising given her professional interest in the disorder. The theme of weak or watery blood is again linked to poverty, which is widely held to exacerbate *move san.* Botanical metaphors pepper her descriptions, which are also rich in herbal lore. Mme. Victor was quite willing to share her knowledge and even expressed a willingness to cull some of the scarcer ingredients. Her recipe was presented as a precise and somewhat ritualized regimen:

> To make the remedy, you soak the roots of *bwa lèt,* the roots of *kayimit, bwa jon,* and coconut, and the leaves of *sorosi* and *fey sezi.* If the person with *move san* is a woman with a nursing baby and her milk has gone bad, you need to add the leaves and roots of *bwa let* and also to add one small spoonful of the spoiled milk to the bottle [that contains the remedy]. This is for the person to drink, and will separate the blood from the milk. . . . But there's more to it than that: you must buy a piece of white soap and a coconut, a bit of coffee, a measure of black beans, and then you bring down the blood (*fe lèt la desann*). You grill the coffee together with the black beans and seven grains of salt. When you've finished grilling, you grind it up in a mortar and put it in a pan, add water, and mix it up. From this you make a compress for both the brow and the back of the head, and keep it moist with the

> concoction all day long. . . . You can also place an empty shallow basket on the person's head and pour the medicine in the basket; it will run down over the head and body. Each time you dampen the compress, also rub down her arms and legs with the medicine. Do this for a week or so. Also put a grain of virgin salt [from a box that has not been used for cooking] in the palm of each hand. Place a grain of salt under each of [the patient's] feet and stand on a palm leaf. She must stand still. This will make the milk return to its rightful place.

Mme. Victor mentioned that there were several variations on this theme, but that these were the "principal ingredients." Some of these versions are designed to alleviate particular symptoms. (If swollen feet are part of the symptom cluster, Mme. Victor adds avocado-tree bark to the mixture.) A slightly different formula was indicated if the *move san* (or *lèt gate*) was caused by *sezisman.* Further, it is perfectly acceptable for someone suffering from *move san* to seek medical care from other practitioners, with the following caveat:

> The medicine I'm telling you about is the best one for *move san,* and you'd better take it before you spend your money to go to the hospital, because hospital medicines can't make the milk go down. After this remedy has made the milk go down, then you can go to the doctor.

Although such herbal remedies are clearly the therapy of choice, there are attendant risks:

> Don't put in too much of the ingredients. . . . If it's too strong, or you give her too much of the medicine, it can make the person go crazy. But if she doesn't take the medicine, the milk mixes with the blood, it rises to the head and that makes her crazy anyway. That's why nursing mothers are more susceptible, and when you don't see any milk, you'd better hurry and take the [herbal] medicine because you can be sure that the milk is going to her head and will kill her.

Further, the family of the sufferer must ensure that no repeated emotional shocks "interrupt the treatment. . . . The weak has to become strong." Unlike Ti Malou and Mme. Kado, Mme. Victor said nothing about the "infiltration of the uterus." When asked about the case of Alourdes (our second case study), who followed a similar regimen without results, Mme. Victor's disapproval was evident:

> If she weaned her baby, she has narrowly missed killing herself; it's the baby who makes the medicine work correctly. The infant sucks out the bad milk and can then be given a purgative (*lók*). Then both mother and child get well together. But if she has *move san* and doesn't take the right medicine, and the milk dries up within her and the child is weaned, she might look healed today, but she'll be sick again tomorrow.

After interviewing two *dokte fey* and several women with a history of successfully treated *move san/lèt gate,* it became clear that the most constant ingredient in the remedy for spoiled milk was *bwa lèt.* Literally “milk tree,” *Sapium jamaicense* exudes an opaque white sap when nicked or broken. Since Haitian ethnobotany so strikingly recalls a more famous “milk tree,” I turn to Victor Turner’s analysis of Ndembu ritual. He reminds us to seek three classes of data when attempting to analyze the structure and properties of ritual symbols: “(1) external form and observable characteristics; (2) interpretations offered by specialists and laymen; (3) significant contexts largely worked out by the anthropologist.”[13] Observable characteristics as described by Mme. Victor seemed to typify those of other healers. The interpretations of “laymen,” who were all women, tended to be rather thin when compared to the explications offered by Mme. Victor. A typical lay response: “The *bwa lèt* separates the milk from the blood; it makes the milk come back to its place. It strengthens the milk, too, and makes it thick again. The nursing child draws the new milk down into the breast.”

The “significant contexts” slowly emerge with repeated interviewing. I attempted to answer basic enough questions: Why might two of our most vital constituents, blood and breast milk, be perceived as potential contaminants? Why would blood become a poison that can mix with breast milk and “climb” into the head or “descend” to the uterus with mortal effect? But before considering this illness in its symbolic register, let us explore the empirical meaning it holds for an “outside authority”—the village’s visiting doctor.

The Doctor’s EM

Dr. Jean Pierre is a thirty-five-year-old graduate of his country’s only medical school. He has been practicing in rural Haiti for almost five years, since the completion of his year-long residency in a small city in the south of Haiti. After moving to the Central Plateau, Jean worked exclusively in the nearby town of Mirebalais; more recently, he has been spending two days each week in the new clinic in Do Kay. I have worked with him for over four years and know that he is from a middle-class family from the country’s southern peninsula. Although he was raised by strict Catholic parents, attended parochial schools, and considered becoming a priest, he avows an interest in voodoo. His grand-uncle was a well-known *houngan,* or voodoo priest, in the area where Jean was raised. Despite professed interest in the local religion, Jean more often seems bemused by his patients’ health beliefs.

Dr. Pierre saw Ti Malou twice: once in Mirebalais during her “false labor,” and again a month or so after her hospitalization. During both visits he spent no more than five minutes per session with Ti Malou. Although I did not tape-record our discussions of her case, I did make the following note at her first consultation:

> Jean states that Ti Malou is in “false labor,” but that otherwise her pregnancy is progressing normally. He attributes most of her problems to folate deficiency,

> although I informed him that she was receiving 1 mg/day of folate supplement. The backache is due, he says, to the normal loosening of pelvic ligaments; the leg problems are sciatica from the same cause. When asked about *move san,* he laughed and said, "Everyone has *move san!* Her blood is 'bad' because she needs more folate and iron. Besides, there's nothing I can do about such disorders." He said that she did not bring up the issue with him, but spoke only of her back pain, diarrhea, a numbness in her legs, and of course the "labor pains."

Worth noting throughout these exchanges are, first, the degree to which the EMs of the patient, the mother, the confidante, and the local healer converge, and second, how little these have in common with the EM held by the doctor. Ti Malou knew very well that, in the clinic, complaints of *move san* were more likely to elicit scorn than sympathy. Again we are reminded that discourse depends on a setting for much of its meaning; rather than being neutrally descriptive, it always interacts performatively with a setting of expectations and admitted interpretations. The patient later insisted that her own etiologies were "too private" to discuss in front of the doctor. When I countered mildly that her disorder did not seem too private in Do Kay, she responded much as Jean had done: "There's really nothing he can do, anyway."

That the EMs of all those who accepted the reality of *move san* disorder should have so much in common ought not to surprise us. *Move san* is a "public health problem" in an unaccustomed sense: an illness with a public meaning. When a whole village knows the participants and follows the course of treatment, a case of *move san/lèt gate* serves as a stage on which social and psychological problems (mistreatment of pregnant or lactating women, for example) can be aired. The doctor refused to admit *move san* into the range of his competence, and the patient tacitly agreed to act as if the disorder had never occurred. Doctor and patient were not, therefore, speaking the same language.

Momentarily putting aside the doctor's opinion of the disorder's etiology and cure, we might sum up the villagers' shared understanding of the *move san/lèt gate* complex as including the following points:

A "malignant" emotion can cause sickness. Such emotions include anger, fright, and shock. Women who contract the illness are more often perceived as victims than as offenders.

Pregnant and lactating women are particularly susceptible to *move san.* They should therefore be protected from these malignant emotions.

If *move san* does occur in a pregnant or lactating mother, one common outcome is "spoiled milk."

With or without *lèt gate, move san* is appropriately but not always successfully treated with an herbal remedy.

- Body fluids like milk and blood are perceived as especially sensitive to "malignant" emotions; disorders involving them can therefore be seen as "barometers" of disturbances in the social field.

This last point, bringing physiological, pharmacological, psychological, interpersonal, and moral forces to bear on the etiology of *move san,* ought to be singled out as just the sort of emphatically loaded cultural *donnée* that an anthropology of suffering needs to examine. In this context, it is significant that Hazel Weidman wrote of a "blood paradigm" that seemed to underlie many of the health-related beliefs of her Haitian American informants.[14]

While a socially recognized disorder like *move san* in some regards resembles a code by which private messages are made public, this should not make us forget that a code can contain personal or regional "dialects," "styles," or "idioms." In Ti Malou's case, we can see personal meaning at work: her illness seems to chart the history of her relationship with Luc, the father of her children. An uninformed observer might not notice the tension that exists between the former mates. But in Do Kay there are plenty of open secrets and forbidden subjects. I recall Mme. Kado's response when I asked her if she still spoke to the woman she held responsible for the death of one of her children: "Do I still speak with her? Of course! With people like that, you never let on that you know they're no good. If you do reveal that you know how bad they are, you'll never have children." Illnesses, therefore, might speak louder than words in contexts such as those from which the *move san* disorder takes its meaning.

One hypothesis comes to mind for certain cases in which *move san* is intractable or difficult to treat: the "illness" might in fact be "illness behavior," a form of chronic somatization that is related to strong social pressures (as, for example, the pressure to avoid confronting those who wrong you). Somatization of distress is, in such cases, a form of metaphoric retaliation or resistance. Although somatization is clearly an important component of *move san,* there are substantial differences between the somatization depicted here and that described by Arthur Kleinman among the Chinese and Margaret Lock among Japanese women.[15] Among Kleinman's Hunanese patients, depression and psychosocial problems were either denied or taken to be the result, and not the cause, of pain. Etiologies were predominantly biologic, these being the culturally sanctioned causes of illness. My informants, in contrast, almost always designated social problems and their psychological sequelae as the cause of their illness but thereafter focused on their abundant somatic symptoms. Among Lock's Japanese informants, also women, we can see more similarities: somatization of distress is a form of women's protest, but the social dynamics of distress, however obvious, are often treated as a forbidden subject. More research should show how similar these patterns are.

Nonetheless, the model of "illness behavior" is inappropriate to many of the cases described by my informants. For a few, *move san* may be more of a coping style, an idiom of distress. For others, it recalls a more acute form of somatization similar to an acute stress syndrome. But if *move san* is in some way adaptive, "the work of culture," why is the outcome occasionally so dismal? As Gananath Obeyesekere writes, "Work also implies failure; if mourning is successful work, melancholia is failure."[16] Where people are under severe nutritional, political, and interpersonal stress, attempts to replace direct confrontation with some "safer" alternative are bound to fail sometimes. Seen as "work," acute *move san* may be successful, while the *move san/lèt gate* complex is frequently a failure.

Should *move san* and *lèt gate* be considered two different syndromes? If so, *move san* seems to be an "etiological category," one that suggests much about the origins of the problem, with wide variation in presenting symptoms. Spoiled milk, on the other hand, is virtually pathognomonic for the *move san/lèt gate* syndrome when it is seen in a previously healthy woman who is not pregnant. Is spoiled milk merely the symptom of bad blood in a pregnant or nursing mother? I believe that *lèt gate* is more than just a symptom of *move san.* Instead, let us suppose, as do my informants, that the two "run together"; it is widely believed that the added factor of milk complicates the course of the malady. It indicates, I suspect, the gravity of the initial offense, the malignancy of the emotion. It recalibrates the barometer.

Further, this barometer gives readings on the larger atmosphere. Everyone in Do Kay shares a background of great material and political stress. Social interrelations and psychological equilibrium are rendered more fragile under these conditions. In much of rural Haiti, women are frequently called upon to perform the Herculean task of providing for children and other dependents. Too often, like Ti Malou Joseph, they must do this alone. During pregnancy, and while a woman is a *ti nouris,* several strict rules are observed, all seeming to reflect a single concern: the protection of the woman. One must avoid, at all costs, startling or upsetting a pregnant or nursing mother. When this "taboo" is broken, *move san* as illness behavior is one means of articulating distress. Obeyesekere asserts that the "work of culture is the process whereby painful motives and affects such as those occurring in depression are transformed into publicly accepted sets of meanings and symbols."[17] In his work in Sri Lanka, Obeyesekere sees the work of culture in the ample Buddhist lexicon of suffering and despair. But the work of culture is found not only in well-articulated ideology or flashy ritual. It is also present in a more subtle illness syndrome that may afford beleaguered women, and especially mothers, a culturally sanctioned and relatively safe means of articulating displeasure with the behavior of consociates. It becomes, quite literally, an idiom in which many forms of misfortune—whether designated by outside observers as social, economic, psychological, or physical—are obliquely presented.

Whether or not an organic basis is ever found for the *move san/lèt gate* complex, it is clearly an illness rich in cultural and individual meaning. It is for this reason, too, that a more broadly conceived approach is now appropriate.

DISCUSSION: MODELS OF AN ILLNESS

A next step in the preliminary assessment of a heretofore undescribed indigenous illness category might be to apply to it several different varieties of cultural analysis, one after another, in an attempt to clarify the nature of the illness, and then compare the results. We shall bring three possible and complementary methods of explaining to bear on *move san/lèt gate.* The first is the meaning-centered psychological and ethnomedical analysis outlined earlier. A number of the questions posed at the outset remain unanswered, suggesting, perhaps, the limitations of an interpretive approach. If it hopes to answer questions of relative risk and changing incidence, an interpretive approach not only must be based on a painstaking phenomenology of illness and grounded in epidemiology but also must incorporate the lessons of history and political economy. Further, a comparative exercise might yield insights not apparent if an "emic" stance alone is adopted. What follows is a pair of methodological sketches, the sole purpose of which is heuristic.

Move San/Lèt Gate as a Product of Economic Forces

Is the *lèt gate* syndrome the product of an economy that forces women away from breastfeeding? In 1975, an estimated 46.2 percent of Haitian women participated in the labor force, making them far more economically active than any of their Latin American counterparts. In the entire Third World, only Lesotho boasts a formal economy more dependent upon women.[18]

In their detailed study of infant feeding practices in a Haitian village they call "Kinanbwa," Maria Alvarez and Gerald Murray note an alarming increase in the "spoiled milk syndrome." Their rural informants "believed that it is possible for the milk of a lactating mother to *gate,* to spoil and turn it into a poisonous substance that may, instead of nourishing the child, harm or even kill it." For this reason, women with *lèt gate* wean their children. As in Do Kay, "the most frequent cause for this is the onset of violent negative emotional state in the female." The authors attribute the "epidemic" to the gradually deteriorating economy of the village in which they worked: "It takes little imagination to perceive the manner in which this 'illness' provides precisely the cognitive rationale for turning to the increasingly early weaning that the worsening economic conditions in the village make practically desirable. The belief complex itself makes possible a behaviorally convenient symbolic metamorphosis of the meaning of early weaning. Traditionally, early weaning was seen as an injustice to the child. But when a woman has *lèt gate,* her early weaning is interpreted as a service to the child." Although Alvarez and Murray do not suggest a monistic economic model, favoring instead one that draws upon intimate familiarity with their informants, they do insist that "the epidemic of *lèt gate* which appears to have come over the village cannot be understood apart from the economic pressures which make early weaning desirable."[19]

It is unlikely, however, that the model they propose will fully illuminate the Do Kay data. First, although the prevalence of *move san/lèt gate* would seem to be as high among my informants as among the Kinanbwa mothers, the lactating women of Do Kay, unlike those who spoke with Alvarez and Murray, do not wean their children when their milk spoils; rather, they seek to treat it. Ten out of sixteen did so effectively. Second, in Do Kay, the threat is seen as chiefly to the mother, not the infant. One of the chief differences between the two groups of women is the Kinanbwa women's almost universal involvement in marketing, an activity that takes them to Port-au-Prince for much of the year. The women in Do Kay do far less marketing but still have a high incidence of *lèt gate.* More work is necessary to determine possible psychological and secondary "gains" derived from the *move san/lèt gate* label. Perhaps the course, rather than the incidence, of the illness is to some extent determined by the mother's occupation. No pattern was discernible among my informants: the six women who weaned their infants were no more involved in marketing than were the ten who continued breastfeeding after successful treatment.

During the past few years, a "critical medical anthropology" has taken shape. Although it seems to have no one agenda, a central criticism leveled against medical anthropology has been its failure to link local ills to the larger systems of domination that often influence or even generate them. Much psychological anthropology is vulnerable to the same critique. My own refresher course in political economy was taught by a more convincing teacher—one of my local informants. Mme. Gracia, a woman in her late sixties, insisted that I not forget recent history. She reminded me to attend to the larger context in which "malignant emotions" arose:

> *Move san* is not something that was regularly seen before [the valley was flooded]. Some people died from it after the dam was finished. Now we are up here and we are poor. We have no livestock, no [sugarcane] mills. We suffer too many shocks (*sezisman*), too many problems. We are poor and we are weak, and that is why you see *move san.*

For Mme. Gracia, as for many of my younger informants, *move san* was a channel through which broader experiences of suffering could be transmitted. That suffering is explicitly related to the humiliating frustrations of poverty, the ineffaceable pain of displacement. Mme. Gracia jogged my memory: seven of the thirty-six mothers with a history of *move san* cited financial difficulties as the prime etiologic factor. Poverty was mentioned in most talk about suffering and misfortune. I do not believe that *move san/lèt gate* is a direct product of economic forces. But I do believe that the weight of material deprivation may change the incidence and course of the illness, and even serve as a causal factor in some instances. In many of the Do Kay cases, then, a modified version of Alvarez and Murray's dictum holds true: the high incidence of *lèt gate* in Do Kay cannot be understood apart from the economic pressures that make emotional stability so elusive.

Move San as a Mental Disorder, American Style

One of the most consistently applied methods of examining a "new" disorder is to attempt to map it onto existing illness categories. This has become especially true if the disorder is labeled "psychological." For example, Ari Kiev has declared that culture-bound disorders "are not new diagnostic entities; they are in fact similar to those already known in the West." Each of the well-described culture-bound disorders, Kiev asserts, is actually an American psychiatric diagnosis in exotic clothing: *latah* is a hysterical disorder, *susto* and *koro* are anxiety disorders, *shinkeishitsu* is really obsessive-compulsive disorder, and so on.[20] As much recent work by anthropologists has shown, there is good reason to believe such transpositions inaccurate.

False starts do not excuse us, however, from seeking a genuine dialogue with other, related disciplines. In referring to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III), we need not surrender our relativism, nor our attempts at autonomous theorizing. We can consider the textbook classifications as offering a comparative perspective, not an authoritative answer. In several circumstances, diagnoses from one nosology have served to illuminate diagnoses from another. In the spirit of such comparison, we will suspend skepticism and consider *move san* as a Haitian version of one of our own official labels. Further, the exercise is best conducted by clinically informed anthropologists with an understanding of indigenous categories, if only as a preemptive strike against those less aware of the slippery nature of categories and labels. With the growing hegemony of North American medicine in Haiti, it will not be long before DSM-III is aimed at *move san* with "therapeutic" intent.

For example, can *move san* be construed as a depressive disorder? Given the primacy of the "psychological" that is manifest in DSM-III criteria for Major Depressive Disorder (MDD), it is unlikely that any of my informants would be diagnosed as clinically depressed. If some of their somatic complaints were judged to be metaphoric expressions of sadness, however, several of them would meet MDD criteria. I am not sure that would be an appropriate or useful diagnosis; in those who are currently afflicted with *move san,* the affective component is more suggestive of anxiety than depression. Of the several anxiety disorders listed in DSM-III, only Generalized Anxiety Disorder (GAD) would be a candidate diagnosis for *move san.* DSM-III stipulates that the essential feature of the new category GAD is "persistent anxiety of at least one month's duration." Certainly, anxiety of one brand or another was present among the vast majority of those women suffering from *move san*, but it did not have the overwhelming character of an "essential feature" and was often of short duration. Further, anxiety is almost as prevalent among those women with no history of *move san.* Raising children in rural Haiti has become an anxiety-generating venture.

Taking the somatization of depression among the Chinese for a model, can a case be made for the somatization of anxiety disorder among rural Haitian women? DSM-III certainly makes it easier to arrive at a diagnosis of GAD than one of MDD. To diagnose the former, "generalized, persistent anxiety" must be continuously present for at least one month. Unlike the criteria for MDD, however, which are imbued with a marked primacy of the mental, the anxious mood may be manifested in symptoms from any three of the following four categories: motor tension, autonomic hyperactivity, apprehensive expectation, and vigilance and scanning.[21] Although a patient such as Ti Malou could be squeezed into a modified, "somatized" MDD category, a diagnosis of GAD might fit her more comfortably. At present, these diagnoses may not be entertained concurrently: DSM-III stipulates that a diagnosis of GAD may not be made when the criteria for MDD or any other Affective Disorder can be met. Since the publication of DSM-III, the hierarchical organization giving precedence to Affective Disorders has come under attack; Robert Spitzer and Janet Williams have reviewed the issues and propose a revision in which a "symptomatically more pervasive disorder preempts the diagnosis of a less pervasive disorder."[22]

One problem with such a "lenient" approach to diagnosis might be that, although criteria can be met using the somatic symptoms, the resulting clinical picture is not strikingly anxious. This leads, of course, to a conundrum and underlines a major source of anthropology's chronic vexation with psychiatry: none of the reported symptoms is specific to anxiety, and none of them allows us to distinguish "normal" from "pathologic" anxiety.

The APA classification holds that the essential feature of Adjustment Disorder is "a maladaptive reaction to an identifiable psychosocial stressor." The maladaptive nature of the response is manifested by "impairment in social or occupational functioning or symptoms that are in excess of a normal and expected reaction to the stressor."[23] If it falls to outsiders to decide what constitutes normal and abnormal reactions, these criteria are more easily met. Because appropriate social functioning for a *ti nouris* includes breastfeeding, and because bottle-feeding so often has adverse effects in settings such as rural Haiti, *move san* as a response to a stressor might very well be considered maladaptive.[24] Yet this diagnosis, even if embellished by tags such as "with Anxious Mood" or "with Mixed Emotional Features," would have no real utility and would offer little in the way of improving our understanding of the disorder.

Just as it would be premature to exclude an organic basis, so too is it unrealistic to consider as psychogenic in origin any illness "for which there is positive evidence, or a strong presumption, that the symptoms are linked to psychological factors or conflicts."[25] *All* symptoms, once perceived, are linked to "psychological factors or conflicts," even those symptoms that are positively valued. More useful in a preliminary examination of *move san* is the term "somatization" as used by Wayne Katon, Arthur Kleinman, and Gary Rosen;[26] they include under that label not only physical symptoms that occur in the absence of organic findings but also the amplification of complaints caused by established pathology, such as a chronic illness. The definition eschews an unrealistic faith in the ability of clinicians to detect "underlying" organic findings or pathophysiologic mechanisms on a case-by-case basis. In over four years of intermittent clinical experience in Haiti, I have never seen anything resembling a complete diagnostic workup.

Psychological reductionism would have us miss the possibility of significant biological disruption; in addition to the medicalization of social problems (for example, neurasthenia in China, "heart distress" in Iran), can we afford to miss or misinterpret the *physiologization* of social and psychological problems? An elegant psychoneuroendocrinologic model could be advanced to explain *lèt gate* (for example, neuromodulatory inhibition of oxytocin letdown or prolactin rise), as well as the more obvious symptoms of autonomic nervous system hyperarousal. And is our own relativism not called into question by our failure to entertain the possibility that *move san* might be just what it is said to be: a blood disorder caused by malignant emotions? Among my informants, the most common explanatory model seems to go *beyond* a somatosocial model—*move san/lèt gate* becomes a disorder of experience, without a great deal of Cartesian anguish as to whether it is more somatic than psychological. The disorder, and their view of it, calls into question the tenaciously dissecting gaze not only of psychiatry but of much medical anthropology as well.

CONCLUSION: MADAME GRACIA AND THE ANTHROPOLOGY OF SUFFERING

Move san is an illness that has not yet been fully described in anthropological, medical, or psychiatric literature. How to begin? Anthony Marsella's suggestion that research start from an emic determination of popular categories[27] is accomplished by eliciting explanatory models from informants in order to clarify how the illness (often not neatly labeled "psychological" or "somatic" by the persons who suffer from it) is culturally constructed. After this preliminary description, how should the illness be examined? I have presented several different ways of interpreting the data—some of them reductionist and functionalist, but all heuristically useful. The mapping of "exotic" disorders onto North American psychiatric-diagnostic frameworks instructs mainly through its inadequacies; it neither helps us understand the "folk" nosology nor gives any assurance that the familiar categories are being applied correctly. In the attempt to formalize imaginary correspondences, an "unreal" illness is reinterpreted to fit the authoritative terms of a "real" one.

Considering *move san/lèt gate* as an interpreted disorder affords a privileged view not only of the disorder but of broader categories of affliction. Viewed as a cultural artifact, the most striking thing about *move san* disorder is the lurid extremity of its symbolism: two of the body's most vital constituents, blood and milk, are turned to poisons. The powerful metaphors serve, it may be inferred, as a warning against the abuse of women, especially pregnant or nursing ones. Transgressions are discouraged by their publicly visible, and potentially dire, results. As somatic indices, "bad blood" and "spoiled milk" submit private problems to public scrutiny. The opposition of vital and lethal body fluids serves as a moral barometer.

Up to this point, the nonbodily factors appealed to by our analysis of the disorder have been largely interpersonal and village-scale. The investigation remains shallow, however, if the "moral barometers" are viewed in a controlled and limited context. A village is not a bell jar, and, as Mme. Gracia attests, the syndrome is related to the historical and economic changes affecting women's increasingly difficult struggle for survival in rural Haiti. In their incisive evaluation of contemporary anthropology, George Marcus and Michael Fischer reach a similar conclusion: "An interpretive anthropology fully accountable to its historical and political-economy implications thus remains to be written."[28] This is no less true of medical and psychological anthropology. It is inexcusable to limit our horizons to the ideally circumscribed village, culture, or case history and ignore the social origins of much—if not most—illness and distress. An interpretive anthropology of affliction, attuned to the ways in which history and its calculus of economic and symbolic power impinge on the local and the personal, might yield new understandings of culturally evolved responses to illness, fear, pain, hunger, and brutality.

It is often remarked that contemporary academic approaches attempt to understand by dissection. We have this attitude to thank for much of our present-day rigor, and also for the specialization that renders accurate characterization of disorders like *move san* elusive. To diagnose such an affliction as somatic, psychological, or even psychosomatic is still somewhat different from and, it may be contended, something far less than examining it as it is experienced and interpreted. Perhaps what is necessary is a concerted and integrated effort, an anthropology that would seek underlying *forms* of suffering common to its many *aspects* (bodily, mental, economic, and so on). An anthropology of suffering would not stray far from the standard concerns of the ethnographer, for suffering strains cultural norms and brings them into sharp relief, as the Haitian material illustrates. Anthropologists are also in a position to discern epistemological and ontological differences (and similarities) between medicalized suffering and suffering that is understood in religious terms.

This is not to be mistaken for yet another call for holism. Rather, it is a reminder of the need to connect personal illness meanings with larger political and social systems. One way to approach such a project is simply to attend more closely to the way in which illness (and other misfortune) is worked into the narrative renderings of broader experience. In a 1986 study of urban, working-class France, we found that concepts such as "coping mechanisms" or "illness behaviors" were useful but inadequate to explore illness as experienced and discussed by our informants, who were mostly Iberian immigrants.[29] Pointed questions about specific episodes frequently elicited long and nonspecific narratives that seemed to address far larger, more existential questions of suffering. These narratives were typically couched in a sweeping "rhetoric of complaint," highly context-dependent and markedly performative. Illness episodes were commonly worked into this rhetoric in an attempt to make meaning out of a broader set of physical and social afflictions less easily classed as "psychological" or "physical" or "social" or "economic." That illness was often conceived in broad terms of misfortune meant that our subsequent analysis was reduced to a struggle, not entirely successful, for parsimony without reductionism.

Last come the moral dilemmas an anthropology of affliction must face. These are not new in our discipline, but they become particularly sharp when suffering forms both the subject and topic of research. Mme. Gracia made this painfully clear when I consulted her regarding the ingredients of the herbal remedy for *move san/lèt gate.* Her response, and the tone in which it was delivered, brought me up short: "Surely you are collecting these leaves in order to better understand their power and improve their efficacy?" Had she added, "If you think we'll be satisfied with a symbolic analysis of *move san/lèt gate,* you're quite mistaken," I would not have been more surprised.

NOTES

1. Scheper-Hughes and Lock, "The Mindful Body," p. 9.

2. Some of the most important research on Haitian "health beliefs" has been conducted, paradoxically, in the United States. Hazel Weidman (*Miami Health Ecology Project Report*) provides the most extended consideration of blood-related beliefs. She and her collaborators encountered *mau-*

vais sang (as interviews were conducted in Haitian Creole, the label may be considered a Gallicization of *move san*) among their Haitian American informants; this and other disorders are considered as parts of a "blood paradigm" central to informants' perceptions of bodily functioning. Also on this topic, see "Haitian Blood Beliefs and Practices in Miami, Florida," by Clarissa Scott, a member of the research team led by Weidman. In research conducted in Haiti, the disorder is also mentioned en passant by Alfred Métraux in "Médecine et vodou en Haïti." It is discussed by Emmanuel Paul ("La première enfance") and considered at greater length in an excellent unpublished report by Maria Alvarez and Gerald Murray ("Socialization for Scarcity"). In his comments on a report by Jeanne Philippe and Jean Baptiste Romain ("Indisposition in Haiti"), Claude Charles, also a member of the Miami team, examines *indisposition* in relation to the blood paradigm prevalent among his informants ("Brief Comments on the Occurrence, Etiology, and Treatment of Indisposition").

3. Interesting cross-cultural comparisons, beyond the scope of this paper, are to be made with the large literature treating disorders caused by emotional shocks, especially illnesses affecting breast milk. Unni Wikan ("Illness from Fright or Soul Loss") describes a group of illnesses called *kesambet* in northern Bali, which are very similar to the *move san/lèt gate* complex. Nancy Scheper-Hughes, working in urban Brazil, has recently described infant "death by neglect," one feature of which was perceived spoiling of breast milk. The discourse of her informants (the women of the community) recalls, I believe, that of many of the Haitian women who speak of *move san* in broad, "existential" terms (see Scheper-Hughes, "Culture, Scarcity, and Maternal Thinking"). There is also a large literature documenting the widespread belief that one's milk is insufficient, but milk insufficiency is not necessarily the same as spoiled milk, nor do we have reason to believe that perceived insufficiency is often caused by malignant emotion. For a review, see Tully and Dewey, "Private Fears, Global Loss."

4. For an overview of the country, see Prince, *Haiti.*

5. Chen and Murray, "Truths and Untruths in Village Haiti."

6. All personal names are pseudonyms, as are "Do Kay" and "Ba Kay." Other geographical designations are as cited.

7. A follow-up survey was conducted at the time of the 1986 census, revealing even higher prevalence (and thus increasing incidence) of *move san* as well as a new case of *move san/lèt gate.* It should be noted, however, that by then my interest in the disorder was well known; perhaps "questionable" cases were politely brought to my attention. Further longitudinal study is necessary to determine the chronicity of the complex and to elucidate patterns of recurrence or relapse.

8. There are, however, other causes of *lèt tounen,* or "turned milk," which often seemed to be synonymous with *lèt gate. Lèt tounen* was usually caused by the conception of another child, in which case the milk was described as "spoiled" or "turned." Many informants used the verb "to steal." One informant explained, "As soon as you become pregnant, any milk in your body must be for the baby in the womb. If the other [the nursing child] steals it, he can become sick."

9. Eleanor Rosch and others have questioned the validity of the prevailing "digital" model of categories, which assumes that "caseness" is determined by the absence or presence of discrete, criterial attributes. Instead, they propose an "analog" method that "represents natural categories as characterized by 'internal structure'; that is, composed of a 'core meaning' (the prototype, the clearest cases, the best examples) of the category, 'surrounded' by other members of increasing similarity and decreasing 'degree of membership'" (Rosch cited in Good and Good, "Towards a Meaning-Centered Analysis of Popular Illness Categories," p. 146). I present here two uncontested cases of *move san;* in some situations, *move san* is suspected to be the cause of certain symptoms, but there is not universal agreement.

10. Good and Good, "Towards a Meaning-Centered Analysis of Popular Illness Categories," p. 148.

11. Following Arthur Kleinman, explanatory models are "notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process" (*Patients and Healers in the Context of Culture,* p. 205). Formulated for each illness episode, EMs attempt to answer questions of etiology, type of symptoms and their onset, pathophysiology, the course of the sickness, and treatment. The methodology, when used in an open-ended way, has proven no less useful when the disorder is perceived as social or psychological in origin. Many of my rural Haitian informants were reluctant to be steered in any direction, however, and I am very tempted to refer to my transcripts as "ENs" (Elicited Narratives), rather than EMs.

12. For an evaluation of this concept, see Janzen, "Therapy Management."

13. Turner, *The Forest of Symbols,* p. 20.

14. Weidman, *Miami Health Ecology Project Report.*

15. Kleinman, "Neurasthenia and Depression"; Lock, "Protests of a Good Wife and Wise Mother." See also Kleinman, *Social Origins of Distress and Disease.*

16. Obeyesekere, "Depression, Buddhism, and the Work of Culture in Sri Lanka," p. 148.

17. Ibid.

18. Lundahl, *The Haitian Economy.* See also Neptune-Anglade, *L'autre moitié du développement.*

19. Alvarez and Murray, "Socialization for Scarcity," pp. 70–74.

20. Kiev, *Transcultural Psychiatry,* p. 66.

21. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders,* s.v.

22. Spitzer and Williams, "Proposed Revisions in the DSM-III Classification of Anxiety Disorders Based on Research and Clinical Experience."

23. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders,* p. 299.

24. Note, however, that Alvarez and Murray ("Socialization for Scarcity") discern the adaptive nature of "the spoiled milk syndrome" among their informants.

25. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders,* p. 241.

26. Katon, Kleinman, and Rosen, "Depression and Somatization: A Review. Part I," and "Depression and Somatization: A Review. Part II."

27. Marsella, "Thoughts on Cross-Cultural Studies on the Epidemiology of Depression."

28. Marcus and Fischer, *Anthropology as Cultural Critique,* p. 86.

29. Gaines and Farmer, "Visible Saints."