HEALTH AS A HUMAN RIGHT AND MEDICAL HUMANITARIANISM ON THE HAITIAN-DOMINICAN BORDER

Pierre H. Minn

Departments of Anthropology and Social Studies of Medicine

McGill University

November, 2004

A thesis submitted to the Faculties of Arts and Medicine in partial fulfillment of the requirements for the degree of Master of Arts

Your file Votre référence
ISBN: 0-494-12747-3
Our file Notre référence
ISBN: 0-494-12747-3

Abstract:

At a government hospital in the town of Dajabón, in the northwestern Dominican Republic, doctors and nurses must make decisions on whether or not to treat Haitian patients who have crossed the border in search of health care. This thesis examines the discourses and practices of Haitian patients and Dominican health care providers in the context of two co-existing but contrasting rhetorics: health as a human right, and medical humanitarianism. Using data collected through semi-structured interviews and participant observation, I examine how social, political, and economic forces shape medical encounters on the Haitian-Dominican border.

Résumé:

Dans un hopital public de la ville de Dajabón, dans la région nord-ouest de la République Dominicaine, les médecins et infirmières doivent décider s'ils doivent ou non traiter les patients haïtiens qui ont traversé la frontière en quête de soins médicaux. Ce mémoire examine les discours et les pratiques des patients haïtiens et du personnel soignant dominicain dans un contexte marqué par la présence de deux rhétoriques contrastées : la santé comme droit humain, et l'humanitarisme médical. En utilisant des données recueillies par l'observation participante et des entrevues semi-structurées, j'examine comment les forces sociales, politiques et économiques structurent les rencontres médicales à la frontière entre Haïti et la République Dominicaine.

Table of Contents

Acknowledgements.....i

Introduction.....1

Part One.....8

A Crowded No Man's Land.....8

Historical Background.....11

Peripheral Migrants, Fighting Cocks and Counterpoint.....14

Methodology.....17

Haitians in Dajabón.....18

Health Conditions in the Area.....21

Who Gets Treated?.....22

"Not Enough for Our Own".....28

Part Two.....31

Health Care as a Human Right.....31

From Universal to Local.....34

Solidaridad Fronteriza.....38

Who Pays?.....45

Having the Right (to) Health Care.....48

Part Three.....56

Medical Humanitarianism.....56

Historical Antecedents.....59

Gift-Giving and Reciprocity.....61

The Sisters of the Sorrowful Mother.....69

Compassion: A Moral Emotion.....75

Shifting Powers and Complex Altruism.....77

Conclusion.....82

Works Cited.....95

Appendix (Research Ethics Approval).....100

Acknowledgements

This thesis was written with the assistance and support of numerous individuals. I would like to begin by expressing my gratitude to the residents of the Haitian-Dominican border, who welcomed me into their homes and lives. Special thanks are due to Dr. Joseph Cherubin; the members and volunteers of Solidaridad Fronteriza; the staff of the Sisters of the Sorrowful Mother's Border Health Project; and all of the patients and health care providers I met with over the course of my research. The people of Hispaniola have suffered for centuries from the invasions of foreign intruders. I hope that my incursions there will not continue a legacy of exploitation and abuse, but rather, contribute to positive changes for the people of Haiti and the Dominican Republic.

This research received generous support from the Social Sciences and Humanities Research Council, the Fondation pour la recherche en santé du Québec and the Max Stern Foundation.

It is a privilege to thank my supervisor, Dr. Allan Young, whose insights and guidance have opened many intellectual doors since I arrived at McGill. I look forward to benefiting from his wisdom and critical thinking for many years to come. Sincere thanks also go to Vinh-Kim Nguyen, who has been extremely generous in his support, offering thoughtful and encouraging comments when they were needed most. Christina Zarowsky read the entire thesis with a keen eye for detail – her critical and encouraging feedback was much appreciated. Committee members Sandra Hyde and Kristin Norget provided useful feedback and enthusiasm for my project, and facilitated my first teaching experiences. I have benefited greatly from seminars and conversations with Margaret

Lock, Mariella Pandolfi, and Shao Jing. I owe Linda-Anne Rebhun at Yale University a permanent debt for introducing me to the field of medical anthropology nearly 10 years ago and for continuing to share her ideas and encouraging me to develop my own.

Colleagues in the Departments of Anthropology and Social Studies of Medicine at McGill have been an endless source of intellectual, practical and emotional assistance. These include Geneviève Dionne, Mauge Brockman, Julia Freeman, Annie Jaimes, Christine Lapierre, Scott Matter, Karine Peschard, Rémy Rouillard, Morgen Smith, and Wilson Will. Special thanks to Hannah Gilbert for her engaging conversations, unwavering optimism and attentive ear. I am fortunate to be surrounded by such a brilliant and generous group of people.

Two individuals deserve special mention: Rose-Marie Chierici facilitated my first trips to Haiti and remains an invaluable resource for helping me understand all things Haitian. Catherine Maternowska, whom I met shortly before fieldwork for this project, has widened my horizons and challenged me to develop important, relevant questions. Every student should be so lucky as to have such mentors and friends.

Finally, I would like to express my sincere gratitude to friends and family who have supported me during my studies. Special thanks go to my parents, Kyungtak and Patricia Minn, whose openness, curiosity, and compassion in our tri-cultural family have served me well in my work.

Introduction

In December of 2001, the Dominican Republic's Ministry of Public Health and Social Assistance published a 116-page report entitled "Incidence of Demand of Health Services by Foreigners," which tracked the frequency and costs, down to fractions of *pesos*, of visits to government hospitals and clinics by foreigners during a three-month period in the same year. The document reported that over 98% of these foreigners were Haitians (SESPAS, 2001: 14). The report was widely diffused and frequently referred to by Dominican media in the months that followed. Many Dominicans consider the presence of Haitian migrants in their country to be a major social problem, and the report confirmed suspicions that Haitians were using up scarce resources in the form of public health care services.

The tables, charts and graphs included in the report belie the complexity of an issue that involves politics, economics, history, and social processes: the provision of health services to populations that are unable to pay for them. As in many parts of the world, shifting and decaying government infrastructures on the island of Hispaniola have created large groups of people whose well-being is guaranteed by no state. In the Dominican context, the Haitian and Haitian-Dominican recipients of health services are often not Dominican nationals, or even residents. Although many come from families that have lived in the Dominican Republic for generations, few have documentation with which to confirm their nationality. Others enter the country specifically to access a hospital or clinic, and return to Haiti immediately after receiving or being refused services.

This thesis will examine the discourses and practices that accompany the provision of medical services to Haitians in a Dominican government hospital. My analysis draws heavily from research I conducted during the summer of 2003 in a hospital adjacent to the Haitian-Dominican border, which Haitian patients regularly cross in search of health care. Over the course of my research, I identified two co-existing but contrasting rhetorics: that of health as a human right, and that of medical humanitarianism. Although I will examine these rhetorics in a particular geographic and social context, they have emerged on a global scale in the past century. They are of particular relevance when addressing the following broader topics: health in the context of social change and poverty; political economy of health; the practice of biomedicine in capitalist societies; and biopolitics. In writing this thesis, I have been guided by theoretical analyses of these issues. My goal is to apply these theoretical frameworks to grounded, empirical data and situate the questions at hand within a specific time and place.

This thesis is divided into three parts. The first part describes my research during the summer of 2003 on the Haitian-Dominican border, and gives a brief overview of the area's history and social context. After presenting some of the recent literature concerning Haitian-Dominican relations, I describe interactions at the Dominican government hospital where I conducted the bulk of my research, and present findings from the interviews and observations I carried out there, both with patients, their families, hospital staff, and representatives from local community groups. I also describe my findings from research with Haitian migrants on both sides of the border.

The second section examines how a human rights framework can be applied to interactions at the border hospital, specifically the concept of health as a human right.

This concept was promoted in the World Health Organization's Declaration of Alma-Ata in 1978, and can be situated within a broader international human rights movement that emerged after World War II. Nearly sixty years after the American Anthropology Association's refusal to endorse the Universal Declaration of Human Rights, the issue of human rights remains prominent and controversial in the field. Anthropological works on the topic, however, have remained limited to a few specific themes, namely the validity of human rights in the context of cultural relativism and the clash between individual versus collective rights. Anthropologists have devoted attention to human rights when studying "traditional" or non-Western cultural practices, but have only recently begun to consider the concept of "the right to health" and its implications for understanding medical practice and health care in contemporary societies. My discussion will situate human rights rhetoric within the realm of lived experience. Endeavors to understand this rhetoric in specific social and cultural contexts need to be multiplied in order to allow for comparative analyses.

The third section is devoted to medical humanitarianism, or the provision of health care to persons in need based on a sense of altruism and benevolence. Medical humanitarianism can take place on an individual level, but is also carried out by groups and agencies. Medical humanitarian organizations today are extremely varied, and range in size from international networks to small, local NGOs. Oftentimes, medical services are included in the work of organizations with more general missions to relieve suffering. In Western societies, medical humanitarianism has been heavily shaped by Christian ideals of mercy, charity and compassion. While these continue to shape contemporary biomedical discourse and practice, the past decades have witnessed a burgeoning of new forms of secular medical humanitarianism. All of the concepts mentioned above

(altruism, benevolence, mercy, charity and compassion) are central to an understanding of the genealogy of humanitarianism in the Western tradition. However, I will focus specifically on the notion of compassion. In addition to its emergence as a central theme over the course of my fieldwork, it also figures in anthropological and philosophical literature as a moral emotion that shapes social interactions in diverse settings.

Both humanitarian and human rights movements have created extensive networks of structures, vast bodies of literature, and a wide range of techniques with which to address the problems they work to resolve. For this thesis, I will focus on an apparatus that is common to both groups: transnational non-governmental organizations. Many of the similarities and differences between the two organizations I studied are representative of the similarities and differences between their respective rhetorics. Anthropologists have contributed significantly to the formation and operation of such groups for decades. Their critical perspectives on the groups' activities are more recent, but have steadily multiplied in recent years, and can be divided into three broad themes: research based on applied projects in public and international health; critical studies on development; and scholarship building on and responding to biopower as described by Michel Foucault. In the first category, concerned anthropologists and activists have called for engaged research as a means of improving health conditions at the local and global levels. In the second category, scholars have offered a critique of the policies and implementation of international development projects, focusing particularly on the relationships between states, NGOs and IGOs. While such analyses have focused on long-term economic projects, the issues they raise are also pertinent to understanding brief, relief-centered humanitarian interventions. The final theme, that of biopower, has led anthropologists to works in philosophy and political science, as they grapple with questions regarding

power, sovereignty, the body politic and the regulation of biological processes. This thesis will draw from all of these intellectual movements in order to address both the structural and symbolic issues that I identified during my research.

While informants did not explicitly mention the terms "health as a human right" or "medical humanitarianism," they frequently engaged in discourses and practices related to them. There is a risk that comes with applying an outsider's frameworks to a foreign social setting. Nevertheless, these terms are effective in conveying important dimensions of the social processes I observed. I have chosen the term "rhetoric" to describe to describe health as a human right and medical humanitarianism, but wish to stress that I am using the term in its broadest sense. While rhetoric generally refers to persuasive speech or language, I will also use it to include actions and dynamic processes that emerge from particular ways of understanding social interactions and identities, and in turn, are employed to obtain results from others individuals. The persuasive dimensions of the term rhetoric are particularly relevant given that humanitarians and human rights workers actively promote their visions and techniques, and aspire toward a widespread implementation of their values and practices at the local, national, and international levels.

Although both humanitarian and human rights rhetorics shaped the discourse and practices of my informants, they can be contradictory in nature. If health is conceived of as human right, a sick or injured individual has the right to receive health services. Therefore, practitioners have an obligation to treat patients -- refusal to do so constitutes a human rights violation. According to humanitarian rhetoric, the indigent patient becomes the object of the practitioner's good will and compassion. The practitioner does not expect to be compensated monetarily for medical services rendered, but rather offers

them as a gift to someone less fortunate. Refusal to treat in this context does not constitute a violation of another's right, but the personal choice of a free agent. Notions of what it means to be human are deeply embedded in both rhetorics, and patients and providers often spoke of the concepts of "human-ness" and "humanity" when describing medical encounters. While these concepts are presented as self-evident, they must be called into question and problematized in order to better understand medical care in impoverished settings.

The individuals I observed and spoke with had varied and conflicting perspectives on the issues I studied. At times, individuals presented contradictory opinions or information in the course of a single account. I interpret these contradictions not as evidence of misrepresentation or fabrication, but rather as indicative of the complexity and density of the situations these individuals confront. Doctors and nurses have a professional obligation to treat the sick and injured, but often lack the resources and capacity to do so. Impoverished patients are often unable to pay for their health care in spite of their arduous labor and careful management of limited finances. In addition, the encounters and interactions I studied took place across a national boundary during a period of heightened political instability and economic uncertainty. An anthropological perspective, rather than dismissing contradictions or attempting to resolve them, makes use of conflicting accounts to better understand complexity and provide a richer portrayal of the situation at hand. It also takes into account the fact that any given social situation is subject to changes and fluctuations. As anthropologists have turned their attention from small, "isolated" groups to the processes that drive and result from social change, they have become more wary of applying findings from one setting to all of humankind, and accept that their research may offer a snapshot portrait of a dynamic process rather

than a definitive, timeless account of a population's "essence" or "nature." Over the course of my own research, it became clear that the two rhetorics I initially identified as contrasting and even conflicting have begun to converge significantly in recent years, and will most probably continue to do so in the future. Therein lies the appeal of developing a sustainable program of research that will permit me to continue studying these issues in the years to come.

Part One

A Crowded No-Man's Land

Less than a hundred paces from the entrance of the Ramón Matías Mella hospital in Dajabón is the customs and immigration office. It is long and beige, with green trim and curtained windows. In the middle of the building is a large archway, over which is inscribed "República Dominicana" in large letters. Five days a week, there is little activity near this building. Soldiers gather in groups of two or three, drinking fruit juices or eating out of styrofoam containers. Dust swirls about in the wind, and the occasional motorcycle or moped sputters nearby, driven by young men and women wearing plastic sandals. By 10:00 am on a summer day, the blazing heat keeps most people indoors. *Bachata*, Dominican "country" music, blares from portable radios, and dogs wander to and fro, seeking out shade under scraggly trees.

On Monday and Friday mornings, however, at precisely at 8 a.m., a steady stream of people begins to flow through the archway, up to a hundred individuals a minute, people of all ages, some running, all carrying bags or tattered suitcases or bundles wrapped in old sheets. Men push wheelbarrows loaded high with bulging sacks, while women sweat under the weight of the enormous parcels and buckets they balance on their heads. Children carry plastic coolers filled with plastic pouches of drinking water or melting ice cream. On these mornings, Dominican guards have rolled open the large iron gates that divide the bridge behind the customs building, and thousands of Haitians, who have been waiting in a long line since before sunrise, are in a hurry to seek out a choice

spot in the largest open-air market on the Haitian-Dominican border. All of them pass directly in front of the hospital.

On market days, the area around the hospital is intense and chaotic. The crowds make it difficult to move about, and the noise and heat are dizzying. People walk and run in all directions, pushing others, yelling at them to move out of the way. Members of a local community organization told me that the frenzy used to be much worse. Motorcycles and cars simply drove through the market, injuring pedestrians and destroying wares. Vendors were stationed haphazardly, so that cabbages could be sold next to used clothing, rice beside automobile parts, crackers with shoes... Military personnel tried to maintain order, often resorting to riding crops or clubs. Shoppers didn't know where to look for what, and sometimes got run over or beaten in the process. In recent years, motor vehicles have been banned from the market, the military has decreased its presence there, and distinct areas have designated for specific products. The streets behind the hospital are reserved for the buyers and sellers of plantains and coconuts, which are transported in open trucks and piled into huge mounds on the pavement. On the streets facing the hospital's entrance, vendors sell large plastic buckets, used for washing clothes, bathing, and carrying water.

I was initially drawn to the hospital because of its location. Less than a minute's walk away from the poorest country in the Americas, the border hospital is the setting for countless human dramas, a space where the social, political and economic dimensions of health and sickness become apparent to even a passing observer. Every aspect of the border hospital, from the disorderly stacks of patient files on dusty shelves (no files are kept on Haitian patients) to the high chain-link fence which surrounds it (built by an

American NGO to keep market activity from spilling into the hospital yard) offered material to inform my reflections on health care in an impoverished, post-colonial setting.

The two nations that share the island of Hispaniola have had a strained but close-knit relationship since their inception as Spanish and French colonies in the 16th and 17th centuries. The Haitian-Dominican border has been the site of battles and commerce, massacres and partnerships. Today, the activities at the border are representative of the larger region's flow of people and goods, the transnational processes that characterize life in the Caribbean. Globalization, migration, and border conflicts are often described as recent phenomena, yet these terms can be applied to virtually any period in this area's history. The movements that began with the arrival of seafaring populations from South America were followed by European conquest and the importation of African slaves, and continue today for millions of Haitians and Dominicans, for whom dislocation in some form is a way of life.

For residents of the Dominican capital of Santo Domingo, *la frontera* (the border) is a distant, isolated region with not enough rainfall or infrastructure to support a substantial population. The border area is "*tierra de nadie*" (no man's land). However, its proximity to densely populated, impoverished Haiti makes it, in Dominican eyes, the part of the nation most vulnerable to invasion and contamination. The border area may be a no man's land, but it is crowded with conflict, tensions, and ambiguity. To understand what forces are at play when Haitians cross the border to sell cheap cologne and used shoes, to eke out a meager living in Dominican cane fields, or to obtain medical services in a hospital with electricity and running water, one must have a perspective on the area's turbulent history.

Historical Background

While the name Dajabón is thought to come from an indigenous term for the Masacre River that forms the northern border between present-day Haiti and the Dominican Republic, few traces remain of the area's early Arawak and Taino inhabitants. Their decimation through massacre, forced labor, and disease was ensured by the Spanish *conquistadores* who settled the area in the early 16th century. The Spanish remained relatively unhampered in their search for precious metals until the 1600s, when French pirates and buccaneers based on the nearby island of La Tortue began forays into Spanish territory. The French engaged in a lively and illicit trade with Spanish settlers in northern Hispaniola, setting the precedent for the commercial transactions that continue between Haiti and the Dominican Republic to this day. The Treaty of Ryswick, signed in 1697, gave control of the western third of the island to the French, who named their colony Saint-Domingue. Spain retained control over the eastern section of the island, known as Santo Domingo.

Although slavery existed on both sides of the island, the society that emerged in Saint-Domingue was exceptionally violent. The relatively low percentage of European colonists (outnumbered by slaves and free blacks 10 to 1) contributed to an atmosphere of tension and oppression throughout the colony. Slaves imported from throughout Central and Western Africa toiled under brutal and deadly conditions to produce sugar, coffee, indigo, and cotton, the sale of which enriched French plantation owners. In 1791, a slave rebellion broke out in the northern part of the colony and spread throughout Saint-Domingue. In the world's only recorded case of a successful slave revolution, Haiti declared its independence from France in 1804, making it the second free nation in the

Americas and the first Black Republic. The violence of the slave revolution sowed fear throughout the Americas, as other slavery-based societies saw the potential for such insurrection in their own lands. Scholars argue that the Haitian Revolution marked the beginning of an era of suspicion and fear toward Haitians that continues to this day (Farmer, 1992:164-165). On the eastern section of Hispaniola, these fears and suspicions were accentuated by the invasion and occupation of Santo Domingo by Haiti from 1822 to 1844. Although historical evidence paints a mixed picture of the occupation (characterized by both the abolishment of slavery and the revival of forced labor, as well as the confiscation of Dominican lands by the Haitian elite) it is remembered in the Dominican national consciousness as an era of tyranny. The Haitian occupation is often conceived of in racial terms, and has been referred to as a period of "Ethiopianization" (Logan, 1968: 32). The Dominican Republic's Independence Day, celebrated annually on February 27th, marks the country's independence not from its Spanish colonizers, but from its Haitian occupiers.

Tensions persisted between the two nations after Dominican independence, and were often fuelled by conflicts in the border area. These conflicts reached their apogee in 1937, during the Dominican military dictatorship of Rafael Trujillo, whose anti-Haitian sentiments were central to his political activity and governance (Franco, 1973: 100). As part of a campaign to "Dominicanize" the border region, Trujillo ordered the slaughter of every Haitian in the area. Estimates of the number of victims range from several hundred to 60,000, with the figure of 20,000 considered by many to be the nearest approximation. Much of the bloodshed occurred in Dajabón, with victims of all ages being hacked to death by machetes and farm tools.

In recent years, much of the conflict between the two populations has centered around the presence of Haitians and Haitian-Dominicans in the Dominican Republic, who work either as migrant laborers, or have settled permanently and established families there. In both instances, these populations tend to work at menial, poorly paid jobs, primarily in agriculture, construction, domestic service, and small-scale commerce. For much of the 20th century, the Haitian presence in the Dominican Republic revolved around the planting and harvesting of sugar cane, whose labor-intensive production provided annual but short-term work for many migrants. Since the early nineties, however, with the drop in sugar prices on the global market, many sugar plantations have shut down, and those that remain were sold by the Dominican government in the mid 1990s. This privatization has had a negative impact on the lives of Haitians and Haitian-Dominicans living on or near plantations, as it has led to a reduction in the already minimal services such as health care and the decay of basic infrastructure such as water systems, sanitation and roads.

Although the sugar industry in its reduced form continues to be an important sector for Haitians and Haitian-Dominicans in the Dominican Republic, it is not cultivated in the province of Dajabón, which is located in the country's arid northwest. With an area of 1,021 square kilometres, it represents 2.09% of the country's total land mass. However, the province's population of 62,046 comprises only .7% of the nation's total population. Dajabón's population density is 60.7 inhabitants per square kilometer, as opposed to the national average of 175.9 inhabitants per square kilometer. Population density for other border provinces is even lower (Silié and Segura, 2002: 33-34; www.one.gov.do). The area has no major industries and little tourism. Local farmers rely

primarily on cattle ranching and crops such as yucca, rice, and beans. These are risky endeavors, as the area is prone to drought.

Peripheral Migrants, Fighting Cocks, and Counterpoint

Recent writings on Haitian-Dominican relations have emerged in a variety of academic fields and in the popular press. They have been produced in the Caribbean, North America and Europe. The authors of these texts differ in their perspectives on how to characterize the relationship between the two nations, and in their treatment of the social, cultural, political and economic bonds and conflicts between Haitians and Dominicans.

Migration has been a central theme in much of the writing on Haitian-Dominican relations. The presence of Haitian migrant workers in the Dominican Republic (primarily associated with the sugar cane industry) has attracted significant concern, particularly in regards to workers' extremely poor living and working conditions on *bateyes* (plantations). The *braceros'* (laborers') plight gained international attention with the publication of French journalist Maurice Lemoine's *Sucre Amer* in 1981. This text, a dramatized account of the lives and suffering of workers sold to Dominican sugar estates by the Haitian government, provoked outrage and targeted responses by international human rights organizations. *Braceros* and *bateyes* have also been studied by social scientists. Franc Baez Evertz, a Dominican scholar, produced several works on Haitian cane laborers in the 1970s and 1980s, focusing on migration patterns, living conditions, and economics. In 1995, anthropologist Samuel Martinez published a monograph entitled

Peripheral Migrants: Haitians and Dominican Republic Sugar Plantations. Martinez wished to draw attention to what he called "peripheral migrants," that is, migrants who do not follow the traditional models of south-to-north, rural-to-urban migration, but rather travel in circular patterns among peripheral zones in impoverished countries. Martinez traces the impact of migration on family members who remain in Haiti, and situates the movement of Haitians in the Dominican Republic within a larger context of globalization and underdevelopment.

Recent scholarship has identified the increased presence of Haitian migrants in other sectors of the Dominican economy (Boisseron, 2000: 198-210). What Silié et al. refer to as the "new Haitian migration" is increasingly urban, young, and female. A growing number of these migrants are fluent in Spanish (Silié et al, 2002: 11-12). Extensive Haitian and Haitian-Dominican neighborhoods are developing in the cities of Santiago and Santo Domingo. But despite the attention given to new trends in migration and settlement, the conditions on *bateyes* continue to be a major concern for social scientists and activists, who are alarmed by the high rates of poverty, disease, and HIV infection found there (López Severino et al. 2000: 20-21, 33-37).

The conflicts that characterize the relationship between the two countries has been highlighted in several recent works. Michelle Wucker's *Why the Cocks Fight: Dominicans, Haitians and the Struggle for Hispaniola* is a journalist's account that draws on the metaphor of the cockfight to describe the relationship between the two nations – their proximity, their confinement in a relatively small space, and their constant antagonism. Matibag (2003) argues against this metaphor, choosing instead to highlight the co-existence and close, if wary, collaboration between the two countries. He compares Haitian-Dominican relations to musical counterpoint, with alternating beats

combining to form a single rhythm. Both of these authors devote more attention to Dominican perspectives, and neither of them relies on social science research. Their usefulness for this thesis is therefore limited.

Finally, race appears as a central theme in many discussions of Haitian-Dominican relations. Howard states, "Dominican identity is constructed *vis-à-vis* Haïti, most notably with respect to race and nation, and through the ancillary variables of religion and language." He goes on to write, "Racial prejudice against Haitians is self-evident. The rural Haitian population is physically segregated as a racial labor enclave in the rural *bateyes*, and socially by racism and popular opposition to assimilation (2001: 2)." According to Howard, "Racial ancestry and the proximity to Haiti underlie a pervasive racial prejudice that devalues the African influence in Dominican society. [...] ...anti-Haitian feeling remains a malignant form of racism that is reproduced across all class groups and in every location (Howard, 2001: 182)." There is also widespread concern that Haitians will carry out a renewed attempt to occupy the eastern half of Hispaniola, and many central figures in Dominican history are celebrated for their efforts to resist Haitian occupation in the 19th century (López Severino et al., 2000: 11). As mentioned above, this occupation is frequently described in racial terms.

On the whole, the works listed above provide useful information on the demographic and historical context that frames my research. However, most authors who have studied the Haitian presence in the Dominican Republic focus on agricultural migrants and Haitian-Dominicans, and do not discuss the issue of individuals entering the country with a precise, short-term goal (such as obtaining medical services). My research will contribute to addressing this issue.

Methodology

The research for this thesis was conducted in the Dominican town of Dajabón (capital of the province of Dajabón), the neighboring Haitian town of Wanament,[1] and their surrounding areas during the summer of 2003. Although previous research in Haiti and fluency in Haitian Creole and Spanish greatly facilitated my work, the short period of time (eleven weeks) for gathering data limited the quantity and quality of information collected. I was able, however, to carry out participant observation research and interviews in a variety of settings on both sides of the border, including hospitals, rural health clinics, marketplaces, private homes, and in the offices of non-governmental organizations. The majority of my research was carried out at the border hospital in Dajabón, where I observed the interactions between Dominican hospital staff and Haitian patients in search of health care services. I received permission from the hospital director to carry out this research, and obtained oral consent from health care providers, patients and their families. When necessary, I acted as an interpreter between hospital staff and patients, whose level of proficiency in each others' language varied considerably. In the hospital, I made certain to inform patients that I was not a member of the hospital staff, and that I was not a medical professional. I explained to them that I was trying to learn more about the situation of Haitians in Dominican hospitals. My ability to communicate with patients in Creole contributed significantly to establishing rapport with Haitian patients.

Over the course of my research, I carried out eleven formal, tape-recorded interviews and held many more informal interviews and conversations, which were

[1] Haitian Creole spellings are used throughout the text. Wanament is the Creole spelling of Ouanaminthe.

promptly recorded in my field notebook. Of the formal interviews, three were with hospital staff, one with a foreign aid worker, and the rest with Haitian patients, former patients, and their family members. All of the taped interviews carried out with Haitians were conducted in Haiti, near the border region, among individuals who had lived and worked in the Dominican Republic and had returned or been deported to Haiti. I did not tape-record interviews with Haitians in Dajabón, as these individuals are often in the country illegally, and a formal interview would have been unsettling. In addition, most of the Haitians I met in the Dominican Republic were working at the time of our encounter – usually peddling wares or shining shoes. While the public nature of their work made it easy for me to initiate conversations, our contact was more conducive to informal conversations and discussions rather than formal interviews. There were also many individuals with whom I spoke on a single occasion, as they returned to Haiti at the end of the day and did not necessarily have a fixed schedule or itinerary for their work in Dajabón. There are very few individuals of Haitian ancestry who reside in Dajabón. Over the course of my research, I also benefited from significant contact with hospital employees, members of local human rights and humanitarian organization, and priests and nuns from parishes in both countries. In addition to the time in the border hospital, I also travelled to rural health clinics, consulted archival material at government offices and research centers in Santo Domingo, and met with social scientists at Dominican universities. All of the above provided valuable opportunities to contextualize the research I carried out in Dajabón.

Haitians in Dajabón

The open-air market at Dajabón is one of the major sources of revenue for the area's residents. In the spring of 2001, it was calculated that over $1,000,000 CAD of economic transactions in agricultural produce took place within a single month (RESAL, 2001: 49). Dominican farmers come to the market to sell eggs, rice, plantains, squash, and livestock, while Haitians sell alcohol, inexpensive cologne, cooking utensils, and used clothing and household items purchased from international aid organizations, as well as a limited amount of agricultural products such as avocados, cashews and beans (RESAL, 2001: 34-36).

Crossing the border can be a simple or complex procedure, depending on one's identity, the day of the week, and the political climate between the two countries. On market days, the gates of the bridge that straddles the Masacre River are left open. The atmosphere at the border becomes chaotic and military surveillance appears relaxed.[2] Individuals are stopped for questioning if they appear to be crossing for reasons other than buying and selling in the market. I witnessed one family who was stopped by border guards because they were carrying luggage rather than bundles of merchandise and appeared dressed for travel rather than commerce. However, most simply pass through the gates, or under the bridge when the river is shallow enough to wade through. When returning to Haiti, Haitians are required to pay Dominican export taxes on goods that have been purchased for resale in Haiti. Dominican customs officials stand in front of the archway to verify that the appropriate taxes have been paid by merchants returning to Haiti.

[2] This relaxed atmosphere is deceiving. Border guards often have a group of young Haitian men working for them, who approach people crossing with the pretext of offering assistance, but with the intention of extorting bribes, which are remitted to the Dominican guard. Resistance on the part of the victim may lead to intimidation and violence.

On other days, or after the official market hours are over, the atmosphere at the border changes to one of more overt surveillance and intimidation. Haitians are permitted to cross into the Dominican Republic if they have a visa, or have made special arrangements with individual guards, arrangements that generally involve bribery and sometimes the exchange of sexual favors. Many Haitians cross over on a daily basis to peddle wares in the streets of Dajabón or to work as domestics in Dominican homes. If the guards recognize a particular individual or group, he may permit them to cross with the understanding that they will return to Haiti at the end of the day. At times, the border may be sealed off completely. During a period of armed insurrections in Haiti in the spring of 2004, all border crossings and the bi-national market itself were suspended.

While Haitians are regularly seen walking in the streets of Dajabón, their movements outside the city are closely controlled and monitored. At all of the roads leading out of the town, the Dominican military has established checkpoints where guards search vehicles for contraband goods or individuals. On buses, dark-skinned passengers are singled out and asked to present identification proving their legal status in the country. Those failing to do so are detained at police or military headquarters, and often deported to Haiti. As a consequence, Haitians entering the Dominican Republic at Dajabón with the intention of seeking out long-term work do not stay in the area, but travel surreptitiously to other parts of the country, where there is less likelihood of being deported. These destinations include the cities of Santiago and Santo Domingo, as well as the agricultural regions of the Cibao Valley and the eastern peninsula. (López Severino et al, 2000: 29-30). I was told several times that even dark-skinned Dominicans preferred not to live in the border provinces, as they are at increased risk of being mistaken for Haitian, harassed, and even deported.

In addition to coming to Dajabón for work or commercial transactions, Haitians also cross the border for other reasons: to photocopy important documents, to use public telephones and to obtain health care. Individuals with the means to pay for private health services opt for a private clinic in Dajabón. The others try their luck at the government hospital. These individuals, the friends and family who accompanied them, and the hospital staff who attended them or refused care made up the population I most closely observed during my time in the field.

Health Conditions in the Area

The statistics that are often used as measures of a population's overall health and well-being reinforce the contrasts between Haiti and the Dominican Republic. They also indicate that health in both countries is relatively poor when compared to North American or European counterparts. Infant mortality in the Dominican Republic was measured at 31 per 1000 live births for the period from 1998 to 2002, as compared to 119 per 1000 live births in Haiti from 1995 to 2000 (ENDESA, 2003: 158; EMMUS-III, 2001: 181-182). In 2002 in the Dominican Republic, 14 percent of mothers reported that their infant had suffered from diarrhea in the preceding two weeks, as opposed to 25.7% of Haitian mothers (ENDESA, 2003: 201; EMMUS-III, 2001: 149). Maternal mortality in Haiti is much higher than in the Dominican Republic: 563 per 100,000 live births in the former, compared with 178 per 100,000 in the latter (EMMUS-III 2001: 200, ENDESA, 2003: 170). In 2001, the World Health Organization estimated Healthy Life Expectancy in the Dominican Republic to be 59.6 years on average, as opposed to 43.8 in Haiti

(www3.who.int/whosis/hale). Health conditions in the Dominican border area are quite poor given the area residents' low standard of living and the paucity of medical services and infrastructure. Rates of HIV in the border area, however, are the lowest in the country. Epidemiologists suspect that this is due to the lower rates of Haitians living there (the rates of HIV infection among Haitians are twice that of Dominicans) and the high rates of HIV on the *bateyes* in the eastern parts of the country (Guerrero, n.d.). Doctors and nurses at the government hospital in Dajabón reported that respiratory infections, malaria, parasites, malnutrition, and injuries from accidents (particularly motorcycle accidents) were frequent.

In addition to the government hospital, there are four private clinics in Dajabón that cater primarily to wealthier residents. Not surprisingly, research shows that poorer individuals in the Dominican Republic are much likelier to visit public hospitals than their wealthier counterparts. When individuals were asked why they consulted at public hospitals, low-priced or free services were mentioned as the primary reason (ENDESA, 2003:306, 322). Patients also seek herbal and magical remedies at a local *botánica*, and there is widespread usage of *botellas* (bottles), which consist of herbs, roots and other pharmacopeia that have been steeped in hard alcohol. The use of these *botellas* is frowned upon by biomedical practitioners.

Who Gets Treated?

When I asked hospital staff, "Under what conditions do you treat Haitian patients?" the answer was invariably "*emergencias*" (emergencies). This category did not

consist of a specific set of illnesses or ailments, but was determined on a case by case basis, usually by the attending nurse or physician. It was generally agreed that Haitians presenting minor ailments or wounds would not receive services. Haitians informants named conditions such as fever, headaches and digestive troubles as examples of conditions that would not be treated. Patients suffering from this type of ailment would not even attempt to access care in a Dominican hospital, and would treat the condition themselves with leaf-based home remedies, seek care at a Haitian clinic or hospital, or simply suffer through the sickness.

Establishing what *did* constitute an emergency, however, proved to be more problematic. Some of the Haitian patients who received care at the hospital over the course of my research included: a child with a coin lodged in his throat, a man who had his hand severed in an accident, several women delivering babies, and a 14-year-old girl with a deep wound in her ankle as the result of a motorcycle accident. I will describe this last instance in some detail, as I was present at the hospital for the entirety of the case, and because it illustrates many of the processes that are involved in the provision of emergency medical care to Haitian patients in this setting.

The girl was carried into the hospital by her relatives. She had been riding on a motorcycle in Wanament with friends, and her heel had gotten caught in the spokes. Her family had taken her to the Haitian government hospitals in Fò Libète and Okap (two and six hours away, respectively), and although doctors in Okap had cleaned and bandaged the wounds, there were no x-ray facilities available there. Doctors in Okap suggested that the girl try to obtain x-rays in Dajabón, and wrote a note to this effect for the family to show border guards. The family crossed with the aid of their cousin, a motorcycle taxi driver on the border who spoke fluent Spanish and was known by the guards. He

appeared to be familiar with the hospital, and knew where to pay for x-rays. After paying 100 pesos ($3 CAD), the girl received two x-rays. The family continued to wait outside the emergency room, hoping that she would receive further treatment. A steady stream of Dominican patients entered and exited the emergency room, and hospital staff ignored the girl, with the exception of a physician, who jokingly pretended to stomp on her injured foot. Several hours later, when all of the other patients had left, a nurse signalled the family to bring the girl in.

The nurse began by having the girl lay facedown on a cot and ripping off her bandages. The girl, who had been silent up until this point, began screaming and wailing in pain, and continued to do so while her wound was being cleaned and disinfected, much to the nurse's obvious frustration. This lasted for approximately twenty minutes. At one point the girl's aunt entered the room for a few minutes, emerged sweating, and announced that the girl would never walk again. After she had finished cleaning and bandaging the wound, the nurse asked me to inform the family that the girl did not have any broken bones and would make a full recovery. She instructed them to purchase a pomade that would help the wounded tissues regenerate. The family seemed doubtful, and asked repeatedly if the girl should have stitches. The nurse responded that the wound was too wide to be stitched. The family seemed unconvinced, but left to purchase the pomade at a nearby pharmacy. As they were leaving, I heard them discussing other purchases they wished to make in Dajabón before returning to Haiti. A few weeks later, I ran into the family's cousin, who informed me that the girl was recovering and beginning to walk.

This case is telling on a number of different levels. What about this girl's predicament constituted an emergency and made her eligible for health care? First, her injury was a localized, easily identifiable and easily treatable condition. Most of the care

I saw given to Haitians in the hospital relied on straightforward technical interventions. Patients were treated for a short period of time and released.[3] Secondly, the girl's family, while not particularly wealthy, was able to pay for the costs associated with care (x-rays, pomade) and would have been able to pay for other costs had they arisen. Finally, the size of her accompanying family group may also have worked to the girl's advantage. Most of the Haitians I saw at the hospital (with the exception of expectant mothers, described below) were accompanied by at least one relative who, in addition to providing companionship, could also run errands, gather information, translate, and come to the patient's defense in cases of abuse or poor treatment. I sensed that a "safety in numbers" strategy was at work for these individuals, some of whom were leaving Haiti for the first time, and were well aware of the hostility Haitians experience in the Dominican Republic.

One kind of "*emergencia*" that consistently received medical attention at the border hospital was childbirth. Attending to Haitian women's births seemed to be a regular feature of work for the doctors and nurses there. While the hospital does not ordinarily keep track of Haitian patients through patient files or other documents, the hospital statistician was able to show me a precise record of which births in the hospital had been to Haitian women. In his record book, a large "H" appeared next to each Haitian mother's name. A nurse informed me that pregnant Haitian women "liked" to give birth in Dajabón because there were no services in Haiti. Another nurse added that giving birth in Haitian hospitals is expensive for the mother, and that in Dajabón, the women received care immediately and recuperated well. Nurses informed me that expectant mothers waited until the last possible moment until coming to the hospital,

[3] To my knowledge, the only Haitian patient who stayed in the hospital overnight during the time I carried out my research was a man who had been arrested and injured by Dominican police. He was under the continual surveillance of an armed guard.

because, "if they come earlier, they don't get treated, they get sent back [to Haiti]." They also added that the Haitian women who come to give birth are generally older women with very few financial resources, and that unlike other Haitian patients, they often come to the hospital alone -- "as if they had no family" -- in order to minimize the chances of being refused treatment.[4]

While hospital staff bemoaned the high volume of Haitian patients they treated, a much larger number remain without medical care. Many of these never even attempt to access services at the government hospital, and those who do have no guarantee that they will receive treatment. In contrast to the example given above, I will describe the experiences of an individual who did not receive treatment, and look at the factors that contributed to a less fortunate outcome than that of the girl with the wounded foot. This individual was a middle-aged woman whom I noticed lying in the hospital yard one afternoon. She was accompanied by her five-year-old niece, who clutched a plastic bag containing their shoes. The woman had been working on a nearby Dominican farm, and had presumably suffered a stroke, which left her paralyzed on the entire left side of her body. She had spent all of her money on transportation to the border hospital, and had no friends or relatives in the area. The hospital staff had given her an injection, told her she could not stay there overnight despite the fact that there were beds available, and carried her out into the yard. Although the woman's state of paralysis, malnutrition and dehydration would constitute an emergency in many contexts, it was considered quite

[4] The issue of Haitian women delivering babies in Dominican hospitals is of particular importance in light of the controversies surrounding attribution of Dominican citizenship to children of Haitian parents. While Dominican law clearly states that any individual born on Dominican soil has the right to Dominican citizenship, Dominican authorities often do not provide proof of place of birth. There is therefore a large population of Haitian-Dominicans who were born in the Dominican Republic and have lived there for many years, but have no documentation to protect them from arrest and deportation. Infants born to Haitian mothers at the border hospital are not granted Dominican citizenship.

*un*exceptional by local standards. A Dominican woman working at the hospital commented, "You know those Haitians. You tell them not to lie down somewhere, but they go and do it anyway." This illustrates that while emergencies are invoked to justify action, they can also be normalized to justify inaction. A few hours later, hospital staff carried the woman out of the yard into the street, where she and her niece spent the night. The following morning, they were transported to Haiti by sympathetic Haitian passers-by, and were not heard from again.

Being refused treatment at a Dominican hospital is often the final blow in an unsuccessful search for healing. The extremely limited availability of health services in Haiti is the primary factor motivating the quest for care in Dajabón. Health conditions in Haiti are abysmal, and Haitian hospitals and clinics are painfully bare. The government hospital in Wanament is lacking in even the most basic medical supplies and equipment. Electricity in the building is sporadic, and doctors talk of having to work by the light of kerosene lamps or candles. Bandages and medications are always in short supply, and the building is in a state of general disrepair. International aid projects provide a large portion of biomedical care available in Haiti. This aid ranges from independent church clinics sponsored by sister parishes in North America to teams of Cuban doctors, nurses, and technicians who have been dispersed throughout the country for two-year assignments since 1997. Such aid projects are unable to meet the needs of the Haitian people, who continue to suffer and die from preventable diseases, infections from wounds, and childbirth. Many of Wanament's residents purchase biomedical drugs in local pharmacies or from itinerant vendors. The use of leaf-based medicine for minor ailments is widespread, as are treatments by local priests and priestesses of the Vodou religion in cases of sent or "supernatural" sickness. For serious "natural" illnesses or

accidents, area residents travel to the Haitian towns of Fò Libète or Okap. Hospitals in these locations, however, have limitations similar to those at the hospital in Wanament. Crossing the border to the hospital Dajabón is often a last resort.

"Not Enough for Our Own"

While health services in Haiti are extremely limited, their Dominican counterparts are far from adequate. Much of the tension regarding the treatment of Haitians in Dajabón lies in the fact that Dominican hospitals and clinics are understaffed, lacking in material resources, and generally run-down. While the hospital in Dajabón has a generator to supply electricity during power outages, clinics in rural areas enjoy no such luxuries. In both hospitals and clinics, there is a regular shortage of medications. The hospital pharmacist informed me that the truck that delivers medications from Santo Domingo was usually behind schedule in its deliveries, and that her shelves were often depleted or completely empty. In such cases, individuals must buy their medications from private pharmacies, travel to larger cities, or simply do without.

That Haitians receive care from Dominican establishments, even if these are not able to provide for Dominicans' needs, is an issue of national concern. The 2001 report mentioned above, which detailed the expenses spent on foreigners in government clinics and hospitals, confirmed and exacerbated this concern with quantitative data. It was cited regularly in widely-read national newspapers, where health care to Haitians was a frequent topic. During the course of my research, I came across several newspaper articles in which hospital directors gave journalists very specific and detailed information

on the amount of money they had spent that year on Haitian patients. I arrived in the Dominican Republic during one of the country's worst economic crises ever. The peso, which in January of 2003 had held relatively stable at 17 per US dollar, had dropped to 35 per dollar by June of the same year. The border area where I worked was particularly hard hit. In addition to rising prices, border area residents have to deal with lack of infrastructure and public investment. "The government only pays attention to the border area right before an election," a Dominican doctor told me. Financial duress affected individuals across class lines. Many of the doctors working at the hospital have other means of supplementing their income. Some work at private medical clinics, others practice veterinary medicine, and several maintain small businesses such as stores or restaurants.

In such a context, it becomes difficult to accuse the Dominican hospital staff of simply "withholding" medical services from Haitians. While the ill treatment of and discrimination against Haitians in all spheres of daily life in the Dominican border area occurs within a larger context of racism and xenophobia, the refusal to treat Haitian patients in Dominican hospitals cannot be attributed solely to these factors. Dominican health institutions simply do not have access to the means or resources to treat the Dominican population. I frequently heard doctors and nurses state that they were sympathetic to the Haitians' plight, but there were just not enough resources to go around.

In this context of scarce resources, racial tensions, and social suffering, providers and patients must negotiate their way through tense social interactions and competing values. Regardless of whether care is given or withheld, all parties involved have strong opinions on the issue of health care for Haitians in the Dominican Republic, and are aware that the questions at hand are serious and weighty. In the discourses and practices I

observed at the border hospital and in the community, two rhetorics emerged that brought the questions into a much larger sphere – health care as a human right and medical humanitarianism. In the following sections, I will situate these themes within the context of the Haitian-Dominican border, and use my research there as a means of illustrating the implementation of universal frameworks in local settings.

Part Two

Health Care as a Human Right

The topic of human rights has been contested in anthropology since 1947, when the American Anthropological Association rejected the universal applicability of the United Nations' Declaration of Human Rights. Discussions of human rights among anthropologists have traditionally centered around two related themes: the tensions between collective versus individual rights, and ethical dilemmas that emerge out of so-called "cultural" practices and non-Western social structures. These discussions have, for the most part, remained abstract and theoretical. In recent decades, there has been a marked proliferation of human rights discourse, practices, and legislation. These have been promoted by non-governmental and governmental organizations, educational and religious institutions, and in all forms of media. Surprisingly, little attention has been paid to the social processes through which the rhetoric of human rights is understood, implemented, and negotiated by local populations. Although the language of rights emphasizes their universality rather than local specificity, the practices and social processes that accompany them vary greatly from setting to setting. As one scholar has stated, "The expression 'human rights' is used as if it was clear, could stand by itself, and need not be substantiated. But it is not, for human rights claims can never be divorced from the particular context in which they are raised (Dembour, 1996: 36)." Because human rights touch on so many aspects of human life, any project to contextualize them should take into account their political, economic, legal, and social dimensions.

In this section, I will explore anthropologists' previous engagement with the issue of human rights, and argue that more ethnographic work on the issue is needed to enrich the theoretical debates on the subject. I will offer my own research as an example of how examining human rights rhetoric in a specific time and place draws the issue into the realm of lived experience and social processes, and allows for an analysis of the layered meanings that human rights engender. Of particular importance is an understanding of how the term itself is being deployed both at the individual and institutional levels.

Human rights in Western society can be traced to the works of Enlightenment thinkers such as Locke and Rousseau, although it has been pointed out that earlier forces, such as the Protestant Reformation and the development of a merchant class in Europe were instrumental in creating a society where concepts such as natural law and natural rights could flourish (Herbert, 83: 2002). Enlightenment thinkers remain central to genealogies of human rights, though, with Locke's concepts of freedom in a state of nature and Rousseau's writings on the social contract frequently cited as fundamental to the development of modern human rights (Bobbio, 1996: 15; Gorman, 2003: 55-57).

While human rights are often discussed as a single entity, they vary widely in content, and each right raises a particular set of issues and questions. The specific right I will discuss, the right to health care, is not among those most often associated with human rights in Western countries (such as the right to vote, the right to self-expression, the right to practice a religion). Rather, it belongs to rights that Messer refers to "*socioeconomic and cultural rights,* [which] includ[e] rights to employment and fair working conditions; rights to a standard of living that ensures health and wellbeing..." Messer contrasts these with "*political and civil rights,* which protect basic security of persons [emphasis in original] (Messer, 1993: 222)." The latter category's prominence in Western

understanding of rights is not new: these were the rights most strongly promoted by Western governments when the Declaration of Human Rights was being drafted. Socialist and Marxist governments, on the other hand, pressured for the inclusion of socioeconomic rights in the Declaration, and contested the predominance of political and civil rights. Today, socioeconomic and cultural rights are often included within larger discussions on globalization, development, and poverty.

Messer argues that anthropologists have been involved in human rights on both theoretical and applied levels, and describes recent work on the subject. She divides her description by geographic region, in the same way that many human rights organizations often target particular issues by continent. This may not be the most useful division, given the wide variation in social and political context that is found within a single continent. While Messer's discussion provides a thorough overview for assessing the involvement of anthropologists in human rights up to the early nineties, her article also underlines the near absence of anthropological work that empirically examines the implementation and impacts of human rights discourses and practices in local settings.

Calls for grounded and contextualized studies of human rights have been sounded in recent years. Wilson (1997) who describes human rights as "one of the most globalised political values of our time," urges for a move away from the universalist/relativist debate, and toward "more detailed studies of human rights according to the actions and intentions of social actors, within wider historical constraints of institutionalized power (1)." This is distinct from seeking out frameworks similar to human rights in non-Western settings. Studies of non-Western equivalents of human rights have focused on literate societies, presumable because such equivalents are easier to identify when formalized in a written legal code (see Donnelly, 2003: 71-88). Wilson

criticizes Renteln's 1988 (538) call for research on local equivalents of human rights, claiming "this seems to be going about the question the wrong way around: instead of hunting for conceptual similarities in different moral traditions, it might be better to look at how concepts are implanted in contexts from which they did not necessarily originate (Wilson, 1997: 13)." This division between "original" and "implanted" rights seems spurious when one considers the rapid changes in social landscapes throughout the world (in which the search for the "origins" of popular concepts may not lead anywhere) and the fact that these processes are contingent on and interactive with each other – pre-existing conceptions of human dignity, worth and rights will necessarily influence how cosmopolitan human rights play out in a particular setting.

In the Haitian-Dominican case, the formal legal documents addressing rights in these countries (national constitutions) can be traced to the philosophies and values of their European colonizers. When one considers the limited access these populations have to these documents, as well as the non-European influences on Caribbean society and culture, these national constitutions are a poor indication of local understandings of and experiences with human rights. Given the expansion of human rights rhetoric into virtually all realms of human existence (identity, self-expression, self-determination, well-being and health...) it is not surprising that an analysis of these understandings and experiences emerged as a central concern over the course of my research.

From Universal to Local

Health is mentioned only once in the Universal Declaration of Human Rights. Section 1 of Article 25 reads:

> "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control (In Gorman, 2003: 198)."

Here, health is intimately linked to "standard of living." The right to medical care is mentioned without explicit provisions for who is responsible for providing such care. Unlike free speech or political association, medical care often entails an immediate financial cost. The lack of means with which to pay for medical care to which one has a "right" exemplifies the contradiction between human rights in theory and in practice. Resolving this contradiction has been a central goal of international public health campaigns in recent years.

In 1978, the World Health Organization drafted the Declaration of Alma-Ata during its International Conference on Primary Health Care. The first item in the Declaration reads,

> "The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector."

The Declaration identifies governments as being responsible for the health of their populations, and focuses on the development of accessible primary health care as the means for obtaining "an acceptable level of health for all the people of the world by the year 2000." Although this document is one of many documents produced by multi-national bodies that call for sweeping reforms in health care and policy, it has become emblematic of a global movement for international health in the late twentieth century.

The document has been praised for the ideals and aspirations it set forth, but has also been criticized for failing to catalyze sweeping changes in global health.

The Declaration of Alma-Ata is representative of what Morgan calls a "virtual explosion of interest in the subject of participation in health." In the Declaration, one finds a synthesis of the major components of the primary health care (PHC) strategy, which include "extending basic health services (such as immunization, sanitation, family planning, and nutritional surveillance) to underserved populations of less-developed countries" and "using community participation to improve health (Morgan, 1993: 62)." The PHC approach was strongly influenced by medical programs in socialist countries, specifically the "barefoot" doctors of Maoist China and felchers in the Soviet Union. It was also shaped by the successes of non-governmental projects, namely in Sri Lanka and India (Mburu and Boerma, 1989: 1005). Authors describing the latter argue that the assumptions drawn from cases of small-scale successes of primary health care interventions have not proven correct in other settings. They believe that the traditional means of calculating PHC success are not good indicators of health care provision: training of community health care workers (training and/or performance may be low), visits by family doctors (these do not equal health care) or the construction/existence of clinics (may not dispense services). The Declaration of Alma-Ata stipulates that government participation is key to implementing PHC, but many projects involving community-based health care have been implemented by non-governmental organizations. Government implementation of most primary health care projects would entail massive restructuring of national health plans and resource allocation (Mburu and Boerma, 1989: 1005-1006). The costs of implementing PHC seem to have been underestimated. Furthermore, governments of impoverished countries have been unable

to cope with the late-twentieth century pressures of debt repayment and drops in the market prices of cash crops (Diskett and Nickson, 1997: 73). Some have pointed out that community participation "was often interpreted as *community contributions* (providing financial support and resources such as voluntary labour) [emphasis in original] (*ibid*: 73)."

In addition to expressing pragmatic concerns about the implementation of the Declaration, scholars have critiqued some of its more fundamental aspects. Navarro (1984), writing shortly after the Declaration was drafted, disagrees with the notion that the World Health Organization is an apolitical body. Arguing that science and technology "carry with them a set of values and ideologies that reflect and reproduce power relations," he cites the example of the barefoot doctor. This model was promoted by the WHO in the 1970s without any public discussion or acknowledgment of the political conditions that gave rise to it in the People's Republic of China (Navarro 1984: 470). To further his point, the author describes four assumptions in the Alma Ata report, assumptions which he characterizes as political and ideological: 1) that the world is divided into haves and have-nots, both at national and individual levels, rather than as capitalist or socialist; 2) that organizational and technological change can be implemented within existing power structures; 3) that potential opponents to change (physicians and pharmaceutical companies) can be convinced that the changes are in their professional and economics interests; and 4) that communities are simply aggregates of individuals, in which power is equally distributed (*ibid*: 471-472). Navarro is also critical of the Declaration's claim that modifications in health services are the key to improving health for the world's population, and argues that improvements in health will develop as a result of changes in economic and social conditions (housing, water, food production,

education), and that these changes, while presented as apolitical, are profoundly political. Navarro argues that "by listing different types of interventions (both outside and within the health care system) is misleading, since the key question (whether they are or are not to be effective) depends on how these interventions are related within a structure and a set of power relations that give their meaning and importance (*ibid*: 472-473)."

Few scholars have commented on the Declaration's form. According to a "Treaty Reference Guide" published by the United Nations, the term "declaration" is used for various international instruments. Declarations include legally binding, formal treaties; interpretative documents annexed to treaties; informal agreements; and reflections of customary international law. The term is often deliberately chosen to indicate that the signing parties "do not intend to create binding obligations but merely want to declare certain aspirations (UN, n.d.:5)." The Universal Declaration of Human Rights is described as a document which "gained binding character as customary law" after it was drafted. Indeed, the UNDHR is generally considered to be the world's most important document with which to evaluate human rights and their violations. The Declaration of Alma-Ata has not received such extensive exposure, perhaps because it is a more recent document, or because its scope is less encompassing than that of the UNDHR.

Solidaridad Fronteriza

Both of these documents, and many others, are used in developing policy and negotiating relationships at a macro level. It is unlikely that more than a handful of individuals living on the Haitian-Dominican border area have read any of these texts.

Nevertheless, given the extent to which the language of human rights has become "pervasive and persuasive (Dembour 1996: 34)," it should come as no surprise that one has no difficulty encountering it there. A major promoter of human rights rhetoric in the border area is the non-governmental organization Solidaridad Fronteriza (Border Solidarity). The group is an affiliate of the Jesuit Services for Migrants and Refugees, an international Catholic organization based in Rome, with a Dominican national office in Santo Domingo. Solidaridad Fronteriza began as a program of the Catholic parish in Dajabón, but became autonomous in 1997. It still maintains close ties with the church, however, as the group's director is one of the parish's priests. In addition to its office in Dajabón, Solidaridad Fronteriza also operates an office in Wanament, staffed by Haitian priests and community activists. The group works on a variety of economic, political and social justice issues in the border area. It provides *apoyo* (support) to local grass-roots organizations, offers assistance to Haitians who have been deported from the Dominican Republic, and has trained volunteers to monitor human rights violations perpetrated by Dominican guards against Haitians, particularly on market days. While health is not a main focus for the group, they do have an informal program through which nuns associated with Solidaridad Fronteriza who live in Haiti "accompany" Haitians to the border hospital. The staff of Solidaridad Fronteriza either hears about these individuals through community networks, or is approached by patients directly. This service is intended for individuals who are unable to cross the border alone, often because they cannot convince the guards to let them cross, or do not have money to pay for bribes. As one nun explained to me, "When we accompany people, they [the guards] say 'Sisters, we know that when you cross, you will come back, you're not going to stay over there.'" The guards' conviction that the nuns will return to Haiti with the patient facilitates the

crossing. For the most part, the nuns accompany patients for X-rays, sonograms, or emergencies that can not be treated in Wanament. The requests for accompaniment occur frequently, but unpredictably. The nuns also serve as interpreters for patients who do not speak Spanish. Having nuns accompany patients is strategically sound -- this particular community is from Colombia, and its members have no difficulty communicating with Dominican guards and doctors. As Latin Americans, Dominicans will identify with them more than with Haitians. Also, the strength of the Catholic Church in the Dominican Republic usually ensures that a certain level of respect is accorded to the nuns.

In different societies and in different medical systems, it is not unusual for patients to be accompanied when seeking health care, either by family members, neighbors, friends, or auxiliary medical professionals. This accompaniment offers affection and solidarity in times of duress, advocacy when confronted with challenges from health professionals or bureaucrats, and logistical support for procedures and tasks the patient may be unable to carry out alone. Viewed from a human rights perspective, however, the accompaniment offered by the nuns working with Solidaridad Fronteriza also situates the quest for therapy within the context of a potential human rights violation. This violation could take place at the border itself, if the guards were to refuse permission to cross or demand bribes of the victim. Additionally, it could take place at the hospital, in the form of neglect or abuse on the part of the hospital staff. Solidaridad Fronteriza maintains a very high profile in the community and throughout the country. In response to human rights violations by police, military, and other local authorities, the group has organized press conferences, held demonstrations, and published eyewitness accounts of abuses. The hospital staff must be aware that inappropriate or questionable activities on their part will be the source of scrutiny by the group, the community, and possibly national and

international forces. Although the organization has the means with which to effectively denounce and call attention to violations, the presence of an accompanying nun at a medical encounter acts as a kind of surveillance or monitoring to see to it that human rights are respected in the first place.

While some of the pressure to treat Haitian patients emerges from the vigilance of outside groups, hierarchies within the hospital may also play a role in service delivery. One nurse at the hospital informed me that, "If a doctor thinks that the patient has to be seen, a Haitian, who comes in with a fever, and the doctor thinks that he has to be seen, then he has to be seen!" Doctors may not always be present or available when such a decision is to be made, and nurses may sometimes be responsible for deciding whether or not to treat patients. In general, however, nurses appear to defer to physicians' judgments, and a survey of over three hundred individuals in the region who had consulted medical professionals in the last month indicated that over 90% of these consultations were with medical doctors (ENDESA, 2002: 302).

In the rhetoric of health as a human right, Haitians who are turned away from receiving care at a Dominican hospital have been the victims of a human rights violation. If the doctor, nurse, or other health professional has the means with which to treat a patient, refusal to do so can be seen as infringing on the patient's right to health. Rights are often described as paired with responsibilities: in order to secure rights from a national government, citizens have certain responsibilities and obligations, such as following laws, not infringing on the rights of others, and contributing to the welfare of the nation. In terms of the right to access Dominican health services, one could make the argument that paying taxes to the Dominican government is the civic responsibility that entitles individuals to enjoy such a right. Haitians, as non-taxed foreigners, would have

no claim to this right under these conditions. The rhetoric of universal human rights, however, transcends issues of national identity to promote rights for all persons, across international borders. The right to health care moves into the realm of need and availability, not taxation. While the Dominican Republic is not a wealthy country, its health care resources, personnel and infrastructure far outweigh those in neighboring Haiti.

As a general rule, the Haitians I spoke with near the border area did not use the explicit human rights vocabulary and rhetoric promoted by groups such as Solidaridad Fronteriza. This does not indicate an absence of human rights ideology among the general population. Notions of human rights are also promoted by the Catholic church, schools, local community organizations, government ministries, IGOs, and the media. They have certainly had an impact on how Haitians understand rights and freedoms, particularly freedom of speech, the press, and political association. The language of human rights in Haiti has become especially prominent since the fall of the Duvalier dictatorship in 1987 and the election of Jean-Bertrand Aristide as President in 1991. The expression of these political rights, their influence on popular organizations and civil society has been well-documented (Farmer, 1994: 125-126, 167-168; Maternowska, n.d.). In terms of socioeconomic and cultural rights, however, more research is needed on poor Haitians' familiarity with and understandings of their "rights" to food, education, and health services, all of which are increasingly rare throughout Haiti.

When talking about receiving or being refused health services in Dominican hospitals, the Haitians I spoke with expressed different ideas and emotions related to rights and justice. Some spoke bitterly of Dominicans' ill will toward Haitians, often using the word *rayi*, or hate, to describe how they perceived Dominicans' feelings toward

Haitians. They claimed that Dominicans were intent on exploiting and abusing Haitians, and would not assist Haitians in need. Individuals spoke of arbitrary arrest, forced and unpaid labor, and the mechanisms that impeded their social and economic advancement. One can discern in these comments a sense of violation and injustice. Access to health in these accounts is not singled out as a particular domain of discrimination or abuse, but is simply one of many resources Dominicans deny Haitians, along with decent paying jobs, adequate living and working conditions, and freedom to circulate throughout the country. Popular commentary on these wrongs describes them as ill will on the part of Dominicans rather than as "human rights violations," although there is a strong sense that Dominicans' treatment of Haitians is inherently unjust.

Individuals also spoke of being *rezinye* (resigned) to their fate. Years of poverty and oppression in Haiti have created a climate in which people do not readily expect positive changes. People may speak of small, short term measures to help alleviate their misery, such as planting a new patch of land or putting their child through another year of school. Overally, though, living conditions have steadily worsened in recent decades, and even Aristide's Lavalas government, which had promised to create lasting and substantial changes for Haiti's poor, became viewed by most with disappointment and cynicism. Talk of perseverance and of not giving up is tempered with words of fatalism, pessimism and discouragement. Haitians' loftiest hopes are often expressed in religious terms, with people describing heaven as a reward for the suffering they have experienced on earth. In this context, being denied health services in a Dominican hospital becomes once again part of a much larger context – this time, it is one of everyday and unextraordinary trials: the struggle to feed oneself and one's family, the constant efforts to maintain one's health

in squalid conditions, and coping with the knowledge that the immediate future holds more threats than promises.

This underlines the fact that the concept of the right to health cannot be considered without a discussion of economic terms, particularly when the health care at hand is practiced in a capitalist system. Like other socio-economic rights such as education and decent housing, there must be means to ensure that resources are available to implement those rights. The individuals I spoke with were acutely aware of this fact, and frequently drew conversations out of the sphere of health and medicine to describe economic realities on a broader scale:

> Author: What happens if someone doesn't have money? That's often the case with Haitians who live in poverty. If someone is sick but has no money and goes to the [Dominican] hospital, what happens?
>
> Informant: I don't think that person would even go, because she knows she'd have to have money. For example, to go to the hospital, you need to pay for a ride in a car, or by motorcycle, if someone can bring you there.

In terms of medical care, some items or procedures such as X-rays and medications had fixed, specific costs, while others, such as disinfecting a wounds or overnight internment appeared to vary according to the situation. Biomedicine's reliance on technological treatments and formally trained practitioners make it an expensive form of health care when compared to other forms of healing on Hispaniola.[1] Even the low prices that result from government subsidies represent an important expense in the budgets of most families.

[1] Leaf-based and/or spiritual healing is not free of cost, however. In urban areas, leaves must be purchased rather than gathered. Consultations with Vodou healing specialists generally involve payment, or at least the purchase of ritual paraphernalia such as alcohol and candles.

Who Pays?

The issue of dispensing health care to foreigners is one that has raised debates throughout the world. One setting that has received substantial attention is the US-Mexico border, which a significant number of Mexicans cross in order to seek employment, services, and residency in the United States. Controversies and complications surrounding the provision of health care to this population are not a recent phenomenon. Nearly twenty years ago, an anthropologist wrote, "Due to the wide variety of laws and regulations that affect the undocumented population, as well as the politically sensitive nature of the issues, there is much misinformation and lack of communication among and between health-care providers and patients on the rights of the undocumented to health care (Moore, 1986: 66)." US federal law explicitly states that emergency medical care must be provided to any person needing it, regardless of citizenship. In the case of indigent patients, however, it is not clear who is to pay for the services, or how to proceed with the provision of non-emergency health care. Conflicts, in the form of lawsuits, have ensued between county and federal governments to ascertain who is ultimately responsible for providing services. While state workers' compensation or private insurance may be the most reliable way to avoid heavy medical charges, few undocumented Mexican migrants have jobs that would permit them to access such programs (Moore, 1986: 67). In 1994, voters in the state of California passed Proposition 187, which denied publicly-funded health care services (excepting emergency care) to illegal aliens. The Proposition never took effect, however, and was declared unconstitutional by a federal judge in 1998.

As in the Haitian-Dominican context, health care is guaranteed in the case of emergencies, but again, determining what constitutes an emergency is not a simple process. Patients in the United States may seek care at hospital emergency rooms because they believe that they will not be turned away. A study among undocumented Mexican and Central America immigrants in California and Texas, found that "when the undocumented use hospital services, they often use emergency rooms..." However, "[e]mergency rooms did not surface as a major source of care when viewed as a proportion of the total services used by interviewees that last time they sought medical care in the United States (Chavez et al, 1992: 21)." Also in parallel to the situation at Wanament and Dajabón, the authors of this study found that many individuals may not consult at all, and argue that "if structural obstacles to health care are lowered, for example, by acquiring private medical insurance, then even undocumented immigrants are likely to seek health care (*ibid*: 22)."

The discussion of the right to health care for undocumented immigrants in the United States revolves around determining who is responsible for paying the bill. As a general rule, a non-citizen will receive health care if his or her condition is critical or life-threatening. Instances in which this does not occur are exceptional enough to receive public and media attention, as in the case of 4-year-old Sandra Navarrete, who died of chicken pox in 1989. Navarrete's parents, undocumented migrants from Mexico, delayed seeking care because, "they did not know where to go, they did not speak English, and they had little money (Jones and Reyes 1989:II:1 in Chavez, 1992: 6-70)." The U.S.-Mexico case differs significantly from that of the Dominican Republic and Haiti, in great part because of the United States' wealth and relatively well-developed health infrastructure and resources. While the numbers of Americans living without health

insurance is troubling, one cannot compare the situation there with that of the Dominican Republic, where the health care system does not have nearly enough resources to provide even basic primary health care for its population.

Negotiating the contradiction between the ideal of health care as a human right and the lack of resources with which to put that right into practice is not a simple task. Doing so entails destabilizing the meanings that are assigned to commonplace terms. In an editorial published in *Social Science in Medicine*, physician and social activist Vuk Stambolovic argues that "human rights cannot be reduced to the ethical intervention of scientists and/or humanists, neither can health care be reduced to technical procedures under the jurisdiction of experts. They might both be vehicles for change, leading toward life no longer suffocated by purely mechanical administration (Stambolovic, 1996: 303)." The author argues that fundamental ontological changes are necessary to effectively promote human rights and health, including challenging objectivism and atomism, as well as promoting a broader concept of the self, so that "by protecting the human rights of the other, one is protecting one's own rights (*ibid*: 303)." While this piece raises some interesting ideas and juxtaposes important concepts, its detachment from any particular setting or body of evidence limits its applicability to the lived context of human rights violations and poor health.

More successful is an article by medical anthropologist Vincanne Adams on human rights in Tibet, which offers useful points and suggestions for "mov[ing] beyond the paralyzing polemic that situates universalism in opposition to cultural specificity when it comes to human rights...(Adams, 1998: 75)." Adams shows the ways in which a metropolitan framework for human rights in individualistic terms has forced Tibetans to individualize their experiences of suffering and abuse, whereas traditional Tibetan

conceptions of bodies and embodied experiences are often social and collective (*ibid:* 83-88). Adams' article provides an opportunity for thinking in terms of a "collective subjectivity" and alternative conceptions of human rights. These new possibilities for working through issues concerning human rights would be particularly applicable in Haiti, where the violation of rights occurs on a wide scale, where the definitions, terms and ideologies of IGOs and NGOs are pervasive but subject to local interpretation, and where discussions of suffering are frequently framed in national and collective terms: "*Ayisyen konn anpil mizè,*" "*Ayisyen ap soufri,*" "*Peyi a fin kraze nèt...*" ("Haitians know much misery," "Haitians are suffering," "The country has been completely demolished...").

Having the Right (to) Health Care

In the health as a human right rhetoric, access to medical services (such as treatment in a hospital setting) is seen as instrumental to a beneficial, desirable outcome for patients. Proponents of the right to health do not generally draw from critical studies of biomedicine that examine the imbalances of power between practitioners and patients in clinical settings. These studies are important in the context of this study, as imbalances in power are inherent between Dominican providers and Haitian patients. Critical perspectives on biomedicine are also relevant to analyses of the health as a human right framework given that many of the proponents of this rhetoric are themselves biomedical practitioners. While documents in favor of the right to health care often speak of such care using adjectives such as "modern" or "high quality," these invariably stand for

"biomedical." From a critical perspective, the pressure to establish health care as a human right can be viewed as the extension of a biomedical hegemony that has been expanding for the last two centuries.

A seminal text in the study of power in biomedicine is Michel Foucault's *The Birth of the Clinic*, first published in 1963 in order to "determine the conditions of possibility of the medical experience in the modern era." Foucault specified that it was "not written in favor of one medicine over another, or against medicine for an absence of medicine [my translation] (Foucault, 1988: xv)." He describes the spacialization of medicine with the emergence of the modern hospital, as well as the intensification of the medical gaze by physicians. Hospitals, which began as centers for the poor and indigent, developed into privileged sites for disease and infirmity. "The hospital is a creator of sickness through its closed and pestilent grounds, and doubly so in the social space where it is placed [my translation] (*ibid*: 18)." The hospital can be interpreted as both an expression and a mechanism of biopower, a site where bodies are disciplined and monitored and where populations are regulated and controlled (Foucault, 1976: 183). From this perspective, the human right to health may also represent the obligation to be healthy.

In addition to the diffuse and internalized forms of biopower described by Foucault, power is also present in more concrete and explicit forms in Haitian and Dominican hospitals. In Haiti, government hospitals and clinics have long been associated with state control, both as manifestations of the Ministry of Health and the government in Port-au-Prince, and through the physical presence of military, paramilitary, and police forces in the hospital setting (Chierici, n.d.). The hospital in Dajabón similarly references the Dominican state both in symbolic and concrete terms.

The hospital is one of the principal government institutions in the province of Dajabón. It is named for a national patriot Ramón Matías Mella (who, significantly, led a Dominican insurrection against Haitian occupants in 1844). Prisoners, both Dominican and Haitian, that have been apprehended by Dominican police or military forces are frequently treated at the hospital, usually for injuries resulting from violence. The presence of their police or military guards and escorts, uniformed and armed, was striking. A Haitian man who had spent weeks interned in a Dominican hospital told me, "When you're in the hospital, it's as though you're in prison. The *gwo chèf* [big guard] is watching over you." The Haitians I observed in the border hospital were visibly nervous and intimidated by the hospital staff. In addition to the stresses of being in a foreign country, poor Haitians are accustomed to adopting deferent postures as a response to the shaming and disparaging treatment they receive in biomedical establishments (Brodwin, 1996, Maternowska, n.d.).

These reflections should not detract from the fact that impoverished Haitians regularly express their need and desire for biomedical services, and are frustrated by the deficiency or poor quality of services that are available to them. Hospitals and biomedical remedies are commonly mentioned along with roads, schools, running water, and electricity as basic resources whose absence causes suffering in Haiti. Furthermore, when present, the presence of biomedicine does not necessarily rule out or hinder other forms of medical practice. Brodwin gives the following description of biomedicine as experienced in southern Haiti, "On the one hand, it is undeniably a metropolitan import, and it arrives with the full weight of foreign power and cultural cachet. On the other hand, it does not threaten to replace the work of midwives, herbalists, and religious healers with its own set of reductionist and culturally foreign interventions (Brodwin, 1996: 56)." In general, Haitians tend to treat their ailments with home remedies such as

leaf teas or poultices, which are more convenient and affordable, and seek care at a clinic or hospital if the condition does not improve or is too serious.[2] It is safe to say that biomedicine is seen as a valuable resource in Haiti, one among others, to be sure, with its particular limitations and strengths. However, extreme poverty, distance, and social unrest have made healing of any kind difficult to access throughout the country. Lack of biomedical resources, whether in the form of an empty dispensary in Haiti or being refused treatment at the hospital in Dajabón, represents one less option in an already impoverished medical landscape.

It is important, however, to keep the issues of state control and biopower central to the discussion of human rights, particularly in the context of national health care systems. As Dembour (1996) points out, "...states, as opposed to private persons, [...] are ultimately responsible for violations of human rights (25)." Reprehensible and violent acts committed by individuals are generally classified as "crimes" rather than "human rights violations." Refusal to treat Haitian patients at the border hospital is more likely to be classified as a human rights violation rather than a criminal act, given that the hospital is a direct manifestation of the government, and the decisions made by its personnel concerning which cases to treat may appear as part of a systematized strategy for dealing with Haitian patients, rather than individuals' acts of compassion or cruelty. Nevertheless, the literal and figurative distance between the hospital and the central government in Santo Domingo is vast, and decisions on which patients to treat, as we have seen, *are* based heavily on doctors' and nurses' individual judgements rather than a systematic set of criteria.

[2] If the ailment in question does not respond to either home remedies or biomedical treatments, it may be identified as having a supernatural etiology, and Christian or Vodou religious specialists will be consulted.

Applying the human rights framework to field settings has meant broadening its scope of analysis, as social scientists struggle to deal with topics and issues not covered in conventional human nights theorizing. Lack of economic and social rights, described by Amartya Sen as "unfreedoms" have received an increasing amount of attention in recent years (Sen, 1999:15-17). In a compelling article on representations of Haitian *braceros* in the Dominican Republic, Samuel Martinez argues that human rights activists, by depicting the *braceros'* plight in terms of coercion and "neo-slavery" have not addressed the economic factors that make Haitian migration to the Dominican Republic largely a consensual phenomenon. He argues, "When human rights activists do not regard dire poverty as a form of unfreedom but ignore it or consider it merely a value-free migration 'push factor,' they participate in sustaining public ignorance of and indifference to the wider issue of poverty and its role in undermining individual liberties worldwide (Martinez 1996: 17)." The author calls into question human rights activists' assumptions that laborers are "free" before their work in deplorable conditions in the Dominican Republic, and hopes to use political economy to straddle Marxist and liberal theories on rights and freedoms (Martinez 1996: 18-21).

This perspective is highly relevant at the border hospital, where one must consider the options for health care (or relative lack of) Haitians had access to before seeking treatment in Dajabón. Categorizing the refusal of treatment as a human rights violations directs attention away from both the abysmal economic conditions in Haiti as well as the scarcity of resources in Dominican hospitals and clinics, and yet, the language of human rights has become an international language used by activists, NGOs of all kinds, governments, and other agents denounce suffering and mobilize action. This takes place in spheres ranging from private conversations to parliamentary sessions and international

summits. When one's goal is to garner international support and funds, the term "human rights violations" is particularly effective. It gains, rather than loses, intensity when exported and decontextualized, whether it be in the form of a published report circulating in North America or a minute-long segment on a television news broadcast. Scholars have asked "[h]uman rights claims carry with them an enormous legitimacy [...] ... why do they achieve this, and why are they expressed in such a form? (Dembour 1996: 35)." A related question would be, why do extreme poverty and the tedium of ordinary suffering not carry a similar legitimacy?

One specific instance of rights discourse deserves particular attention, for what it can tell us about how this kind of language is deployed. I witnessed an encounter between a border guard and an employee of Solidaridad Fronteriza, who was inquiring about the possibility of waiving visa entrance and exit fees for members of the group, who cross the border on a daily basis. Such an arrangement had been made with another guard, but this particular individual was not pleased by the request. *"Nosotros también tenemos derechos!* (We have rights too!)" the guard scowled. The term "rights" in this case are an example of what Wittgenstein terms "language-games," specifically in the sense that language is being *used* to attain a desired effect. Using children's language learning process to illustrate, he states, "...the children are brought up to perform *these* actions, to use *these* words as they do so, and to react in *this* way to the words of others (Wittgenstein, 1953: 4e)." Although people may not be conscious of the ways in which they are using human rights language, and their motivations and reactions may vary, it is clear that its deployment is not inconsequential. Individuals on the Haitian-Dominican border may use the language of rights in order to situate themselves as morally upright people; to signal the presence of a monitoring apparatus of international institutions and

agencies; or to increase the validity or intensity of a claim by referencing a greater source of power. In this particular language-game, "human rights" is used by human rights organizations to garner respect and situate the "violation" at hand within the context of something much more vast: universal justice. The soldier, on the other hand, used the term to remind the NGO worker that the Dominican state was not to be dismissed.

The case described above of the paralysed woman who was thrown out of the hospital represents a single instance among many in which Haitians do not receive urgently needed health care. Some may never attempt to seek care, anticipating that they will be turned away or might be deported. And while human rights rhetoric may be present in the border area, imported by human rights organizations such as Solidaridad Fronteriza, international bodies such as the Pan-American Health Organization or even the Haitian and Dominican governments, human rights violations occur on a regular basis in both countries. In the cases of refused treatment at the hospital, it is unlikely that there will be any legal consequences or prosecution of hospital staff, who are seen as acting within *their* right to choose which Haitians they wish to treat. National legal structures are not called into play by any of the parties involved: "...human rights are (predominantly) extralegal not because they correspond to 'natural' moral rights but because they serve to articulate political claims which make sense in a particular social context (Dembour 1996:33)." The poverty of the Dominican state and its inimical relationship with Haiti do not create a social context where Haitians' political claims can effectively be articulated.[3] While the border area has received attention at a national level

[3] This is not be the case in the *bateyes*, where human rights violations against Haitians have received considerable international attention. This is in part due to the juxtaposition of impoverished Haitian cane cutters with wealthy land and factory owners, as well as the consumption of sugar on an international market.

in the Dominican Republic, it is primarily to denounce the poverty of Dominican border residents. The political claims being made there by groups such as Solidaridad Fronteriza to denounce human rights violations are not receiving attention significant enough to make major changes in the situation in the area.

Often obscured by the depersonalized language of rights and violations, individuals continue to strategize and negotiate within their limited means. It would be misguided to attempt to characterize poor Haitians as wronged victims, noble combatants, or fatalistic pessimists. The individuals I spoke with and observed belonged to all of these categories and many more, depending on the moment in time, the situation at hand, and the other actors involved. We should not be surprised to find conflicting and competing perspectives within a single account, as these are indicative of the shifting nature of human experience and social relations. I spoke with a Haitian woman who had been deported from the Dominican Republic back to Haiti, where she was living in a resettlement camp with her husband and five children. She had worked in the Dominican Republic for years, and spoke of the Dominicans' hatred of Haitians, their violence toward them and the exploitation she had faced there. When I asked her, however, if she felt that Dominicans had an obligation to give health services to Haitians in the Dominican Republic, she seemed puzzled by my question. "Of course!" she answered. "We'd die if they didn't!" She knew much better than I did the extent to which Haitians *are* dying for lack of health care, both in their own country and *lòt bò* [on the other side].

Part Three

Medical Humanitarianism

As I have described in the previous pages, the lack of both human and material resources make it impossible for Dominican medical staff at the border hospital to provide adequate health services to the area's residents. Hospital staff often comment that they are unable to meet the needs of their own nation's population, much less those of the neighboring country. Therefore, any medical services that are rendered to Haitian patients represent a selection of some kind by doctors and nurses. In the chasm that separates the ideal of "health for all" with the reality of resources for few, practitioners choose to provide services, or choose to refuse them. This section discusses the rhetoric of medical humanitarianism, and describes how its discourses and practices shape interactions at the border hospital. I will focus specifically on the work of a U.S.-based foundation, whose work in Dajabón exemplifies the political and social complexities that accompany humanitarian medical activity.

I use the term "medical humanitarianism" in this thesis to describe the provision of health care (in the form of services, treatments, or products) by a biomedical practitioner to a sick or injured person whose capacity to pay for the care is restricted or non-existent. Health care in this context is understood by practitioners and patients to be a benevolent and kindly gesture on the part of the practitioner, who has been moved to action by the patient's condition. The practitioner is not obliged to treat the patient, but does so out of compassion and benevolence.

Humanitarianism is heterogeneous in its origins, expression, and motivation. The term encompasses a wide range of philosophies and human relations. While humanitarian approaches and practices vary significantly depending on the individuals and groups implementing them, it is possible to speak of a "'humanitarian community' [that] includes thousands of individuals working around the world for a wide variety of organizations – national governments, UN agencies, the Red Cross movements and NGOs." These individuals are involved in extensive transnational networks, and share information, resources, and meanings (Wood et al., 2001: 3). Humanitarianism also takes place outside of formal group settings, in daily interactions between individuals.

In the Western medical tradition, charitable and merciful teachings and acts are often associated with Christianity, although this association may neglect similar practices and philosophies from other religious traditions (Jones, 1993:1469). Isaac (1993), who defines humanitarianism as "a feeling of concern for a benevolence toward fellow human beings," claims that it can be found in monotheistic and polytheistic societies around the world, and describes it as "a common heritage of humankind (21)," rather than a uniquely Christian value.

In the Haitian-Dominican border area, however, humanitarianism does find its most common expression in a Christian framework. The Catholic Church has had an enormous impact on the social fabric of both nations, and the presence of Protestant denominations in both countries is steadily increasing. The most prominent humanitarian medical activities in the area are coordinated by an order of American nuns, whose work will be described below.

Although medical humanitarianism on the Haitian-Dominican border takes place on a wide scale and involves major institutions, it is often interpreted in individual and

humanized terms. This may be due to several factors. Although hospital staff have a uniform classification for cases which are worthy of receiving services (*emergencias*), this category is not well defined, and treatment ultimately depends on individuals' judgments. In addition, there are no visible clues that indicate to Haitians that their presence in the hospital is permitted by official policies or regulations. Without a designated waiting area, special hours of services, or documentation such as files or forms, Haitians' medical encounters at the border hospital are indeed highly individualized. Finally, even if the services and resources are ultimately traceable to the Dominican government, it may simply be easier to conceive of this distant, abstract entity in concrete, human terms. For example, a woman waiting with her friend in the emergency room told me that if Haitians received care in Dominican hospitals, it was because the Dominican state had a "good heart" and described the medical services as "favors." Another informant, when asked if the Dominican government had an obligation to treat Haitian patients, replied "According to me, I would say yes, but it depends on *leta* [the state], what it knows and what reasons it has. I can't say that it must give services, but as for me, I would have to give if I had."

Patients were not the only ones to describe medical care to Haitians in such terms. Some of the Dominican hospital staff also used similar language. One nurse, when asked about Haitian patients, replied, "We attend them *con mil amores* [with a thousand loves]." Doctors and nurses frequently used the term *humanitario* (humanitarian). They also used the term *humano*, which can be translated as either "human" or "humane," and I suspect that the latter translation more accurately conveys the connotations expressed in their comments. Some referred to the care provided to Haitians as *asistencia* (assistance), but they also used the standard medical term *atender* (to attend to). For the most part,

Dominican practitioners spoke to me quite matter-of-factly about caring for Haitian patients – it was simply something that made up part of their work days. Given my position as an outside observer and as someone who spoke openly about his experiences in and connections to Haiti, informants may have concealed negative attitudes toward Haitians that are commonplace among Dominicans of all social backgrounds (Howard, 2001: 182). Some hospital employees, however, took pains to clarify that if Dominican health care providers treated Haitian patients, it was because of "*razones humanas*" (humane reasons) rather than obligation. One health outreach worker explained, "...the Dominican State, does not have... should not have any responsibility to give health services to Haiti because we are an independent nation. But for humane reasons and because we share the same island... But we are two independent countries." Social processes on the island of Hispaniola are regularly described in such nationalistic terms, despite the common origins of the two countries as former European slave-based colonies, the migration between the countries, and the extensive economic, social, and cultural ties which bind people on both sides of the island.

Historical Antecedents

Medical humanitarianism today is part of a larger history of colonialism and globalization. Arnold cites the "...frequency with which medical practitioners and imperial proconsuls cited medicine as evidence of the humanitarian zeal and high-minded benevolence of colonial rule, and even to justify the very fact of colonialism itself (Arnold, 1993: 1393)." Although international health projects had diverse origins, either

through military conquests, as part of an effort to gain religious converts, or as a means of protecting colonizers from native ailments and health concerns, they have been and continue to be carried out with strong conviction and determination. Roemer writes, "There can be little doubt that inspiration from religion or political conviction or a spirit of international goodwill has figured prominently in the extension of international health work (Roemer, 1993, 1420)."

The establishment of multi-national bodies for the promotion of international health was an important development in the history of modern medical humanitarianism. Some of the earliest work in the field emerged from the responses of charismatic individuals in 19th-century war zones, namely Florence Nightingale and her nursing in the Crimean War, and the Genevan Henri Dumont, who, in response to the horrors he witnessed at the Battle of Solferino during the Franco-Austrian Wars, began work that would eventually lead to the establishment of the International Committee of the Red Cross and the Geneva Convention (Echavé and Chomienne-Abboud, 2002: 103). The Office International d'Hygiène Publique (1907), the Health Organization of the League of Nations (1918), and the World Health Organization (1948) and its regional subsidiaries have worked toward a variety of goals: monitoring and controlling the spread of infectious diseases, improving rates of vaccination, carrying out sanitation projects, improving nutrition, and standardizing medical practice throughout the world (Roemer, 1993, 1424-1426). In the decades following World War II, an increasing portion of international groups' resources was spent on relief (including health care) to impoverished or war-torn countries. Bilateral assistance programs (one-to-one aid from wealthier countries to poorer ones) eventually surpassed multi-lateral programs, and the United States has emerged as a major donor of international aid. Roemer describes the

activities of the World Health Organization as moving from "specific to general," culminating in the broad health goals stated in the Declaration of Alma-Ata in 1978 (*ibid,* 1427, 1430).

Another major event in the history of medical humanitarianism was the foundation of the NGO Médecins Sans Frontières in 1971 by Bernard Kouchner, a French physician. The group was and is characterized by a commitment to action, and is vocal in denouncing injustice and brutality. MSF is more explicit in expressing its political stance than many other humanitarian organizations: "...putting an end to the silence imposed by legality and its two corollaries: the principle of neutrality and the duty of restraint [my translation] (St Pierre, 2002: 52)." The organization has inspired other bodies to place human suffering and sickness at the center of international policy. While MSF's philosophies and practices may differ significantly from other organizations (evangelical Christian missions, for example), it operates alongside such groups in many parts of the world.

Gift-Giving and Reciprocity

Humanitarianism is based on the provision of goods, services, or assistance toward individuals in need by those who are able to do so. At its core, humanitarianism is thought to be motivated by altruism – sentiments of compassion or benevolence that motivate action. Humanitarian action is generally instigated by witnessing suffering – an observer is moved when seeing or hearing of another's plight, and subsequently acts to rectify the situation. "Pure" humanitarian activity must be free of all self-interested

motives. Even if many of the individuals carrying out humanitarian aid are professionals in their field and renumerated for their work, general understandings of humanitarian activity hold that it is unspecialized, de-personalized, de-politicized and that it lies outside the realm of economic exchanges. Although humanitarian activity is often targeted toward populations, it must emerge from outside a targeted population to be sufficiently disinterested. While humanitarian aid involves a broad range of social interactions and processes, I will discuss it here in light of a classic anthropological area of interest: gift-giving and reciprocity. I do so in the hopes of conveying the complexity of a process which is often described in simplistic terms.

Discussions of gift-giving usually focus on material objects. However, actions or gestures are often included in definitions of gifts: "any exchange of goods or services with no guarantee of recompense in order to create, nourish, or recreate social bonds between people is a gift (Godbout 1998: 20 – in Osteen, 2002: 2)." Medical humanitarianism to Haitians in the Dominican Republic consists of both tangible goods and professional services. Although biomedicine as practiced in the Dominican Republic lacks much of the resources and technologies available in wealthier countries, patients potentially have access to pharmaceuticals, imaging technologies (x-rays and sonograms), apparatus for physical therapy or rehabilitation (crutches, wheelchairs, and splints) and basic medical paraphernalia such as antiseptic solution and sterilized bandages. None of these are readily available to the majority of Haitians. While they are often in short supply in government hospitals and clinics in the Dominican Republic, they still play a central role in biomedical practice there. According to a national survey, expenditures on medication make up 53.7% of the reported costs of hospital visits in the Dominican Republic, as opposed to 9.7% for consultation fees (ENDESA, 2003: 312). Haitians who

have received what they feel to be high-quality care in a Dominican hospital often stress the provision of tangible items. An elderly Haitian woman described her encounter in a Dominican hospital after having being bitten by a dog:

> Author: "When you got to the hospital, how were things there?"
>
> Informant: "When I got to the hospital, they treated me. It was at night. They treated me, they took off my shoe, it was full of blood, and they gave me a shot. They say that when a dog bites you, they give you a tetanus shot. They gave me one. I got better, they only gave me one shot, when they were done, they gave me pills."

A man described his experience receiving treatment for a fever in similar terms:

> Author: "How were things at the [Dominican] hospital?"
>
> Informant: "Well, while I was at the hospital, they took very good care of me. They gave me food, they gave me shots, they gave me... pills. [...] It was even better than being at home!

Some informants emphasized the low or zero cost of medication. One man described receiving pills for a friend suffering from typhus:

> Informant: [At the clinic]... they gave me a lot of medication for her.
>
> Author: A lot?
>
> Informant: Yes, and I only gave them... 100 *goud* ($4 CAD). I only gave them 100 *goud*, that's what they had me pay... [...] They gave medication, and then they... the 100 *goud*, with the lab analysis, everything, for 100 *goud*. 100 *goud*.

Haitians' reactions to the medications they receive in Dominican hospitals is based on contacts with biomedicine and biomedical technology in Haiti. When available, biomedical products in Haiti do not remain within the clinical sphere, but are sold in public marketplaces by itinerant vendors, and are consumed at home according to individuals' and families' notions of appropriate dosage (Brodwin, 23-24,56-57). Even in rural and sparsely populated parts of the country, biomedical remedies are regarded as precious and powerful commodities. Injections are particularly valued. While biomedical remedies are always lacking in Haiti, sponsorship by international

governmental and non-governmental sometimes make them available to the general population at little or no cost.

Anthropological concern with giving goes back to the early days of the discipline. A seminal text on gift-giving is Marcel Mauss's *The Question of the Gift*, which continues to serve as a point of reference for scholars writing on the subject today. Mauss described patterns of exchanges in "archaic" societies, namely in Polynesia and among coastal groups in the American Northwest. He also wrote about "survivals" of these forms of exchange, both in written legal traditions, and in 20th-century societies. Mauss writes, "The unreciprocated gift still makes the person who has accepted it inferior, particularly when it has been accepted with no thought of returning it. [...] Charity is still wounding for him who has accepted it, and the whole tendency of our morality is to strive to do away with the unconscious and injurious patronage of the rich almsgiver (Mauss, 1990: 65)."

He continues:

> "All our social legislation... [ ] ... is inspired by the following principle: the worker has given his life and his labour, on the one hand to the collectivity, and on the other hand, to his employers. Although the worker has to contribute to his insurance, those who have benefited from his services have not discharged their debt to him through the payment of wages. The state itself, representing the community, owes him, as do his employers, together with some assistance from himself, a certain security in life, against unemployment, sickness, old age, and death (67)."

The principle of social security is rarely applicable to the case of Haitians in the Dominican Republic, even those whose families may have been living and working there for generations. Because Haitian-Dominicans often do not have documentation to prove their legal status in the Dominican Republic, or proof of their participation in the Dominican economy, they are not considered worthy recipients of state-sponsored social

services. During the state ownership of the country's sugar industry, it appears that workers on *bateyes* received minimal health care and other social services. With the privatization of this industry in the mid-1990s, even these meager provisions virtually ceased. For Haitians at the border hospital, whose claims to Dominican citizenship are virtually non-existent, their cases will simply not enter into the system of securities described by Mauss. Haitians' poor reputation in the Dominican Republic, either as unassimilated resident aliens, parasitic migrant workers, or desperate neighbors, is unlikely to act as an impetus for change.

Mauss identified three obligations in gift-giving – to give, to receive, and to reciprocate. In light of his writings on the unreciprocated gift, it is important to note that the humanitarian relationship implies inequality in power. Humanitarian activities in North America are directed at animals, prisoners, and the populations of developing countries. The root "human" in the term refers to the humanity of the giver, not of the receiver. And yet, it is important that the recipient be a sentient being – plants or objects cannot be the targets of a humanitarian intervention. Humanitarian activity is based on empathy – the giver must be able to situate himself or herself within the recipient's experience. While stitching a wound or feeding a child, the humanitarian is able to empathize to some extent with the suffering individual, most likely having been injured or hungry at some point in time. On the other hand, humanitarian workers rarely experience the suffering and trauma they address to the extent of the populations living through them. Even though Dominican hospital staff face their own economic difficulties, they are unlikely to face hardships as grueling and daunting as those most of their Haitian patients must confront on a daily basis.

If we accept Mauss' theory that there is no free gift, and that all gifts are motivated by self-interest in some form, this leads to reflect on the advantages or benefits that Dominican health providers could expect to reap by treating Haitian patients. One possible benefit associated with humanitarian activity or philanthropy is an increase in social recognition and status. In societies throughout the world, rewards are given to the generous in the form of public recognition, visibility, and the increased moral status that comes with the pubic identity of being a humanitarian or philanthropist. This does not seem to be an important consideration at the border hospital. The long-standing animosity between Haitians and Dominicans has tempered Dominican efforts to assist the Haitian population, and such acts are generally not worthy of public celebrations or acclaim. While individuals within certain social contexts (churches and community organizations) may celebrate humanitarian initiatives targeting Haitians, there are also pressures and sanctions against such efforts. I was informed that hospital staff may be chastised or penalized if they too readily offer medical services to Haitian patients. Doing so may be considered unpatriotic, wasteful, or irresponsible, particularly in conditions where Dominican patients are in want of scarce medical resources.

Osteen writes that too much attention has been placed on reciprocity, and that "to discover the true nature of the gift, we must redirect our gaze from reciprocity toward other principles and motives. When we do, a different set of norms emerges, a set founded upon spontaneity rather than calculation, upon risk instead of reciprocity, upon altruism in place of autonomy (Osteen 2002: 7)." This approach is particularly relevant in the border hospital, where it is quite clear that Haitian patients receiving the gift of

health services will not be able to reciprocate this gift.[4] Most return to Haiti immediately after receiving services, may know little or nothing about the nurse or doctor who provided care, and are not likely to maintain any sort of relationship with the provider. Many are so impoverished that they would be unable to reciprocate with cash or goods at a later date, even if given the occasion to do so. Dominican providers are surely aware of this when they dispense health care to impoverished Haitians, and reciprocity is therefore unlikely to be a motivating factor.

While the works of Mauss and other early anthropologists may provide some insights into the social aspects of humanitarian giving, the emphasis on gifts as material objects circulating in small-scale society limits its applicability in the setting at hand. The work of Richard Titmuss on blood donation, particularly in England and the United States illustrates some of the social aspects that accompany a gift that is at once a material substance (blood) and a service (its donation). Furthermore, blood donation, like humanitarian aid, links individuals who might otherwise have no contact with each other. Humanitarian medical aid shares several other features with blood donation: constraints placed on who is entitled to give and receive; a lack of penalties for not giving; the lack of a future reciprocal gift; the fact that givers in both cases would not *want* to have an equivalent gift in the future; and that the gift has very different potential consequences for the giver than for the receiver.

Titmuss, borrowing Sorokin's concept of "creative altruism," argues that gifts "are creative in the sense that the self is realized with the help of anonymous others; they

[4] This is in the case of patients who are unable to pay for care. Those who do pay for the services are involved in economic exchange rather than gift-giving, although some Dominicans might claim that providing any health services to Haitians, even if paid for, represents goodwill and generosity.

allow the biological need to help to express itself (Titmuss, 1970:212)." The "biological need to help" of the 1970s may be comparable to the contemporary search for an "altruism gene," and while such reductionist concepts do not do justice to social phenomena, Titmuss' argument that gifts lead to processes of self-realization for givers should not be discarded. He concludes that donors were "taking part in the creation of a greater good transcending the good of self love. To 'love' themselves they recognized the need to 'love' strangers (239)." Blood donations and humanitarian activity are impossible without the presence of a receiving Other. One cannot be a compassionate person without the pre-existing suffering of another actor.

In response to economists who would push for the commercialization of blood donations and transfusions, Titmuss argues that "Because [social policy] has continually to ask the question 'who is my stranger' it must inevitably concerned with the unquantifiable and unmethodical aspects of man as well as with those aspects which can be identified and counted (224)." And while the British blood donor and the Dominican doctor may have very different strangers, they may be experiencing similar "unquantifiable and unmethodical aspects" related to their constitution as humane and humanitarian persons. For Titmuss, there was much more at stake in voluntary blood donations than the health of the receivers or the self-realization of the givers. He is explicit in his belief that the kind of gift relationships exemplified by voluntary blood acts as a force for social cohesiveness, and that treating blood as a market commodity would reduce the sense of fellowship and belonging essential to a harmonious social life. In this sense, the Haitian-Dominican situation offers a contrasting picture. Haitian patients are not considered to be part of Dominican society, despite their proximity to and involvement in all spheres of Dominican life. Humanitarian aid in this context may

actually increase the division and distinction between Haitian and Dominican populations, given that, unlike blood recipients, who may one day have the opportunity to be blood donors, Haitians are not expected to ever be in a position to offer humanitarian aid to Dominicans. Although Dominicans health professionals may see in their Haitian patients' wounds and sicknesses the pathologies of a common humanity, the construction of Haitians as a fundamentally different kind of human through racist and nationalist discourse precludes the building of unity and solidarity through assistance or aid, which, it must be acknowledged, flows in a single direction. As mentioned previously, Haitian contributions to Dominican society through labor, commerce, or cultural influences are seen as invasive threats.

The Sisters of the Sorrowful Mother

Humanitarian medical activity is an increasingly international phenomenon, and the services and medications rendered to Haitian patients at the border hospital do not originate solely from the Dominican government. Since 1997, a U.S.-based Catholic foundation has sponsored a program that provides low-cost surgeries and other health services to the Dominican border area. The foundation is sponsored by a community of nuns (The Sisters of the Sorrowful Mother, or SSM) who offer a variety of health and social services throughout the Dominican Republic. These include caring for the sick, education programs, and evangelization. The group's administrative headquarters in the Dominican Republic are located in the city of Santiago, over two hours drive from Dajabón. The program is directed by doctors and nuns who pay regular visits to their various field sites. Their activities in Dajabón began with day care programs for young

children, and expanded to include the project at the border hospital, which is commonly referred to as the *convenio* [agreement]. By all accounts, the *convenio* has had a major impact on the hospital, both in terms of physical structures, staffing and health services. The program focuses on surgeries, but also includes the provision of low-cost sonograms for pregnant women. It pays the salary of two physicians who work at the hospital full-time, and of several physicians and technicians who come to the hospital on a weekly basis, including a gynecologist, a urologist and a sonogram technician. The SSM has also established a traveling rural health team for the area, one that aims to support and supplement the services offered by rural government clinics and health posts. The traveling health team consists of a general practitioner, a pediatrician, a nurse and a medical assistant, who visit communities once a month to carry out health education and promotion programs. These include vaccination campaigns, workshops, movies and training health facilitators in the community. These facilitators receive ongoing education every four months at a large meeting – topics include breastfeeding, nutrition, treating diarrhea, STIs and pregnancy.

The *convenio* began in response to a perceived absence of government services in the area. During my time in Dajabón, I was repeatedly told that the border area is generally neglected by national leaders and politicians, mainly because of its distance from the capital. Population density is also taken into account by government officials: politicians seeking votes invest more resources and energy into crowded, urban areas. While the border may serve as a useful theme for political rhetoric, (i.e. protecting the nation from Haitians), its population suffers from lack of infrastructure and basic services. Individuals involved in the program pointed out to me that a new hospital had recently been built in Santo Domingo, and that the existing hospital in Santiago had recently been

renovated. In short, while the border area is referred to frequently in inflamed political rhetoric, it receives little in terms of resources and services.

Government neglect and limited hospital resources were only part of the motivation for establishing the program. All aspects of accessing health care, especially surgeries, are complicated for area residents. The nearest facility offering surgeries before the *convenio* began was a government hospital in Santiago. Travel there represented a major cost in terms of time and money – some individuals reportedly made the journey by horse and donkey. Once there, I was told that patients "*no saben hablar ni caminar* [don't know how to walk or act]," referring to their inability to negotiate a large urban space and the bureaucratic procedures of a major hospital. Because of how consultations were scheduled, patients from Dajabón often had to arrive in Santiago a day in advance. Following their consultation with a general practitioner, appointments with specialists were made for a future date, requiring yet another trip to Santiago.

Once the patient has secured an appointment, there was no guarantee that she or he would receive treatment. Dominican hospitals were described to me as *cuellos de botellas*, or bottlenecks -- places where too many patients vie for few resources. Dysfunctional technology, poorly trained staff, and generalized irregularity all contribute to poor outcomes for the patients. Individuals with *llaves* (keys, or personal contacts) will have a greater chance of securing treatment. Some patients resort to bribery. The combination of these factors made it nearly impossible for impoverished border area residents to undergo surgeries. Instead, in the words of one doctor, "*se resiñaban, lo dejó a la voluntad del Señor* [they resigned themselves, left it to the will of the Lord]." It is important to note that when describing the origins of the *convenio*, informants focused as much, if not more, on structural and bureaucratic inefficiencies and abuses as on patients'

needs. Additional examples include: certain hospital directors obtaining more funds based on ties with government officials, a sense that individuals in power are only looking out for themselves, purchases of poor quality medicine and falsification of receipts for reimbursement. One informant told me, "You wouldn't see this kind of thing in the United States – no one there will risk going to jail for a hundred dollars. Here in the Dominican Republic, there aren't enough jails for all the thieves!"

The foundation's reaction to this situation was described in pro-active, interventionist terms. A doctor and administrator told me what his thought was at the time: "*Soy cirugano, vamos a operar!* [I'm a surgeon, let's operate!]." The foundation felt that the border hospital would be able to support the surgery program. An early priority was to improve the hospital's physical structures and resources. The surgical room had been unused for twenty years, and no one knew where the keys were. The hospital had no generator, water dripped from the ceiling, the X-ray machine was broken, and the building was in a state of general disrepair. The foundation addressed these problems, and added to the existing resources with the purchase of a sonogram machine. It also funded the construction of a fence surrounding the hospital, because of the tendency of crowds to spill into the hospital grounds on market days. Other interventions included providing training for the local staff, many of whose skills had deteriorated over time, or may not have been well-developed to begin with. I was told that the nurses didn't know basic sterilization practices. Some physicians were found to be barely competent in their field of specialization. The foundation attempted to remedy these problems by recruiting bright, young interns to work in the hospital, as a means of shaming the doctors there into brushing up on their own skills and knowledge. These endeavors generated a certain amount of conflict. My own perspectives on these conflicts

are limited, as both hospital staff and program representatives were reluctant to discuss them. Additionally, the five years that had passed and program's relative success had attenuated many of the tensions. I was informed, however, that there were still some "*enemigos del programa* [enemies of the program]" in the hospital, and that the programs' staff come across some minor difficulties when working with the hospital staff, for example, people being late to meetings or the main source of electricity, a generator, being out of gas. One informant stated that "*hay gente que sacan mas ventajas del desorden* [there are people who have more to gain from disorder]."

Overall, however, the consensus seems to be that the program is a success. The foundation has achieved its goal of making low-cost (300-1500 pesos, or $10-50 CAD) surgeries available for the border population. Basic surgeries, such as hysterectomies, cataract removal, and the removal of tumors take place on a regular basis. Over 2000 patients have been treated since the *convenio* was established, including poor patients from as far away as Santiago. Although the program is quite costly for the foundation, administrators stressed that it was a *programa* [program] rather than an *operativo* [operation], with the distinction being that the first term refers to something sustainable and long-term.

It was initially unclear to me whether or not Haitians were eligible for the services offered through the *convenio*. When I asked project administrators about their target population, they told me that they work with "*los más pobres, olvidados, y disposeídos de todo* [the poorest, forgotten, most dispossessed of all]." I asked if this included Haitians, and was informed that yes, since the beginning of the *convenio,* treating Haitians had been part of the program's "*naturaleza* [nature]." In a telling statement, the program's director said, "*No existen diferencias entre haitianos y dominicanos – nosotros vemos*

patología, gente enferma [There are no differences between Haitians and Dominicans – we see pathology, sick people]." One of the program's administrators, a Dominican doctor, compared anti-Haitian sentiment to other, politically-motivated social trends, such as a temporary crackdown on the use of cellular phones by motorists or recent U.S. discourse on terrorism. He acknowledged that these movements were far-reaching, but stressed that they were short-lived in their intensity. Despite the fact that anti-Haitian sentiment was particularly strong when the program began, services to Haitians were already included in the *convenio*'s formal, written objectives. Services have been rendered to Haitians since the program began. And despite the widespread discrimination and prejudice against Haitians, which medical staff are not above perpetuating, the *convenio*'s directors assured me that the program would continue, as it was "*una obra de Dios* [a work of God]."

While the group's work in the border hospital involves agreements and cooperation with the Dominican government (including use of space, collaborative work on health programs, meetings with government ministers), no such ties exist with Haitian authorities or Dominican border guards. There are no specific agreements with the guards that permit Haitians to cross to obtain services through the *convenio*, and the program's administrators were unsure if the guards were even aware of the program. Less than a mile away, at the Haitian government hospital in Wanament, administrators knew that patients cross to Dajabón for medical services, but were unaware of the SSM's program, and have no official policy or program for referring patients to Dajabón. Like many other NGOs working with Haitians, either in Haiti or abroad, the SSM sidesteps the Haitian government altogether.

Paradoxically, the *convenio* is also an example of how humanitarian organizations are involved in multi-national relationships at every level. The order of nuns who oversee the program was founded in Italy and have projects in eight different countries. The *convenio* also receives funding from the Spanish government and UNICEF, and cooperates with local Dominican NGOs. Three medical residents from Wichita, Kansas spent two years in Dajabón as part of the program. The simple signs posted at the hospital that read, "SSM Dominican-Haitian Border Surgery Project" do not convey the multi-national nature of the project, the rationale or motivations of its founders, or the means through which it is implemented.

Compassion: A Moral Emotion

The terms used to characterize the sentiments motivating humanitarianism are varied: mercy, charity, altruism, agape, pity, and others. Each of these carries its own specific meanings and connotations. For the purpose of this thesis, I will focus on compassion, as it, better than the other terms, represents the moral and emotional dimensions of the humanitarian discourse and activities I observed during my research.

The concept of compassion has a lengthy history in Western philosophy, much of which centered on its classification as an expression of sentiment or reason. At the root of the concept is the notion of "suffering with." The theologian Oliver Davies describes it in the following terms: "...the recognition of another's condition, entailing a degree of participation in the suffering of the other, an embrace of that fellow-suffering and a

preparedness to act on their behalf." Davies identifies an early proponent of compassion in the Latin world in the works of Lactantius, a third-century Christian poet.

> "Lactantius' argument is principally that God gave animals natural strength with which to protect themselves, while to human beings he gave the corporate strength of compassion... 'in order that man might show kindness to others, love them and cherish them, protecting them from all dangers and coming to their aid.' This is the 'bond of human society', and it is '*contra naturam*' for us to harm other human beings. [...] Lactantius' view of the role of compassion as the fundamental principle of human society is summed up in the line: 'since God is kind, he wished us to be a social animal: and so we should think ourselves in other people' (Davies, 2001:235).

Davies goes on to trace compassion in the thought of Adam Smith, Rousseau, Kant and Nietzsche, arguing that these thinkers were influenced both by Christian teachings on "fellow-suffering" and Stoic philosophies which favored a detached sympathy based on reason that would form and strengthen social bonds. Nietzsche went as far as to condemn compassion as unwholesome, self-indulgent, and responsible for the spread of unnecessary suffering (Davies, 2001: 235-240).

Compassion is often included among the moral emotions. Moral emotions have been described as emotions that "*are linked to the interests or welfare either of society as a whole or at least of persons other than the judege or agent* (italics in original) (Haidt, 2003: 853)." Haidt classifies compassion as a member of the "other-suffering" family of emotions, and favors the term over "empathy" or "sympathy," which describe the "ability to feel what another person is feeling, including happiness, anger or boredom (*ibid*: 862)," rather than a particular emotion in and of itself.

Emotions resembling compassion can be found in societies around the world. Writing about the concept of *ngaltu* (compassion) among the Pintupi of Western Australia, Myers explains that it "can be best understood as the possibility of being

moved by another's wishes or condition. In daily life, this 'compassion' is both a characteristic quality of social relations and a commonly alluded-to concept." He argues that showing compassion is "a social requisite, and not necessarily the expression of an internal state. [...] By displaying 'compassion,' whatever the motivations, one's act is presented in a favorable light for oneself and for others (Myers, 1986: 115-177)." Emotions, rather than being intensely personal or private states, are in fact deeply embedded in social processes, both at the level of experience and expression. While compassion for suffering Haitians on the Haitian-Dominican border is often described as a dyadic relationship between practitioner and patient, it is in reality part of a much larger network of social relations and collective sentiments.

Shifting Powers and Complex Altruism

Although humanitarian organizations have been active in different forms for the past century, social scientists have only recently turned to examining the social processes that accompany their activities. Mariella Pandolfi, writing on humanitarian organizations in the Balkans, has identified new forms of "supra-colonial" powers that are deployed in an increasing numbers of settings around the world. "Ethnographic research suggests that these transnational bodies impose institutions and conceptions of citizenship that are foreign in territories where the power of the nation-state has never been established [...] or where it has been eroded, or demolished [my translation] (Pandolfi, 2002: 34)." Pandolfi's analysis has been instrumental in my own research, directing my attention toward new forms and instruments of power. The directors of the *convenio*, in their

elaborate and precise descriptions of the Dominican state's failure to provide for their citizens, situate their project as an explicitly political one, and yet shy away from such politicization in their claims of seeing pathology rather than nationality. The conflicts between the program's administrators and the hospital's administrators are a prime example of the tensions that emerge out of contests for power under a weak state. International organizations, particularly those with substantial funding and resources, can establish themselves as major players in the local political economies of the communities in which they work. In further research, I hope to gain a better understanding of the relationships between the Haitian state and the many agencies and groups operating in Haiti. Doing so would allow me to assess whether Pandolfi's use of the term "supra-colonial" is applicable in this country, where colonial legacies have had such a marked influence on the life of its people.

When viewed critically, the targets of humanitarian medical interventions at the border hospitals are not Haitians as citizens, subjects, or even non-resident aliens. It is their life-processes, their injuries, wounds, and pathologies which are subject to the biopower described by Michel Foucault (1976: 183). The social and politicized life of Haitians remains a mystery to most Dominicans, only a small fraction of whom have ever set foot in the neighboring country. Dominicans often refer to Haiti as "*allá*" (over there), and are quick to emphasize the differences between themselves and Haitians. Haiti, for Dominicans, represents death, embodied in starving peasants and sickly infants, but it also represents life, in the form of too many dark bodies, teeming with bacteria and viruses, threatening to overrun the eastern portion of the island as they did in the 19th century (Simmons, n.d.). A doctor from Santiago told me, "People from the [Dominican]

border area are the lowest category in the country. The border dweller is considered Dominican, but barely. So border people repeat the discrimination against Haitians."

From the patient's perspective, humanitarian medical aid at the border hospital is sporadic and irregular – it will usually only occur a single time, following a serious injury or accident. From the practitioner's perspective, however, care to Haitians is a regular feature of work at the border hospital. The medical services rendered are depersonalized – provider and patient are often unable to communicate, and it is unlikely that their paths will cross after their encounter. Yet this depersonalization does not imply the absence of very human processes and meaningful interactions. In the same way that the Dominican government sought to obtain a view of the "big picture" of medical services to foreigners (Haitians) through statistical measures of cost and frequency, applying anthropological perspectives to this issue is just as revealing, and gives new insights on the social dimensions that characterize this assistance. Foremost among these is precisely the discordant perspectives that different actors will have of the same social interactions, which in this case, are already controversial and contested.

The conflicts and tensions that accompany humanitarian aid have been identified by aid workers themselves. These conflicts take place at multiple levels. Writing about humanitarian activity in the last ten years, two doctors write, "Never before has the degree of confusion between war and humanitarian action been so evident (Echavé and Chomienne-Abboud, 2002: 101)." Others have written about the conflicts that emerge between providers and recipients of aid. In a field report prepared by Dutch aid workers in Somalia, it was found that the dominant image the workers have of themselves and their work was that of "benefactor 'here to help,'" whereas the dominant perception the Somali recipients had of workers was "imposing" (O'Keefe et al., 1993 :32). While there

is a widespread awareness of this type of conflict among humanitarian workers, the tools and language available to them may not be sufficient to foster critical reflection on the work at hand. For example, in a report on European aid to East Africa, a "side effect" of aid is described in the following simplistic and ambiguous terms: "Dependency on aid agencies led to problems of disengagement (*ibid*: 37)."

On an individual level, humanitarian motivations are also complex, despite their portrayal in simple, unambiguous terms. "Humanitarian motives are conceived of as exclusive, and they should only be pursued for the desire to do good. This perspective is reinforced, in cases of conflicts and massive human rights violations, by the idea that the affected populations would only consider an intervention to be legitimate if it is wholly disinterested [my translation] (Daudelin and Seymour, 2002, 164)." In reality, these motives are much less straightforward. An official at Oxfam writes,

> "What are our feelings when we see the victims of famine and war: the starving child, the distraught mother, the old person whose way of life has been destroyed? We experience not just one feeling, nor purely a sense of altruistic concern, but other feelings of which we would rather not be conscious. Maybe a little smugness because the same thing has not happened to us. Perhaps even a sense of superiority, crediting ourselves with cleverness because we have protected ourselves against such terrible misery. Such feelings give a pleasant sense of self-confidence and we feel even better as we roll out our prescriptions for solving the world's problems (Vaux, 2001:1)."

He goes on to say "...problems arise from deep contradictions in the notion of humanity – which is, in a sense, a selfish desire to assuage our own feelings of compassion for those in need as well as a desire to be altruistic (Vaux, 2001: 173)." Some authors, recognizing the impossibility of isolating "pure" motives or maintaining a façade of detachment and disinterest, argue that we must move past this "fixation" for neutrality and instead strive

for a "pragmatism based on principles [my translation] (Daudeline and Seymour, 2002: 181)."

In juxtaposing medical humanitarianism with health as a human right, I have attempted to contextualize two rhetorics that are often discussed as though they exist outside of time and space. The contradictions inherent in the two rhetorics do not impede them from coexisting, and when authors talk about the "right to 'humanitarian assistance'[my translation] (Echavé and Chomienne-Abboud, 109)," we can assume that more work on these issues is forthcoming. Addressing them adequately poses a major challenge, as they are wrapped up in basic and fundamental notions and meanings of humanity, and what it means to be human. "I call 'concern for the person in need' the principle of humanity. It is not a simple concept. It is as complex as the person for whom we feel concern, and includes their entire social, economic and political context. To do justice to our concern we have to know everything, and because we cannot do this, altruism is an aspiration, not a fact (Vaux, 2001:2)." Similarly, anthropological endeavors to better understand and work with the social context that is inherent in the human rights and humanitarian rhetorics will have to acknowledge the vastness of the task and be mindful of the ever-expanding realms they seek to address.

Conclusion

In this thesis, I have attempted to illustrate and analyze some of the social processes that are associated with the provision of medical services to Haitians in a Dominican government hospital. In my analysis, I have distinguished between human rights and humanitarianism in order to deepen my reflections on the discourses and practices I observed. The distinction between these is not absolute. Many of the aspects discussed within the context of one rhetoric are relevant in the other - "language games" are relevant to medical humanitarianism, and many human rights workers drawn on the theological sources associated with humanitarianism. In fact, it should be emphasized that human rights and humanitarian operations are increasingly converging, borrowing the others' language and tactics. Minear (2002) explains that this rapprochement intensified during the 1990s. On one hand, human rights organizations began to include the promotion of economic, social and cultural rights within their mandates. At the same time, humanitarian groups became increasingly concerned with addressing the structural and political inequalities of humanitarian catastrophes. Minear claims that "From each side, the perceived convergence of relief and rights represents a major conceptual breakthrough (Minear, 2002: 41)." As mentioned above, recent promotion of the "right to humanitarian aid" illustrates to what extent these movements have become intertwined.

In considering the convergence between humanitarianism and human rights, it is pertinent to examine the work of Paul Farmer, a physician and medical anthropologist based at Harvard University who has worked extensively in Haiti for over twenty years. Farmer is best known for his work in the area of health and social justice, arguing for the

provision of health services to the "destitute poor." Farmer has been enormously influential within anthropology and medicine, and both his clinical practice and numerous publications have attracted attention worldwide.

Farmer's intellectual framework draws from several sources. He has developed Galtung's concept of structural violence in order to illustrate the pernicious effects of poverty and inequalities on the health of populations and individuals. He has also been heavily influenced by world systems theories developed by scholars such as Wallerstein and Mintz, and uses them to trace the effects of global commerce, neo-liberal economic policies and international development projects on the health of individuals living in what appear to be remote areas (most often, rural Haiti). Farmer also draws from liberation theology, namely the endeavor to understand the forces of oppression in order to overthrow them.

One of Farmer's most vehement arguments is against the notion that health care for the poor must be "cost-effective." He claims, "A human rights approach to health economics and health policy helps to bring into relief the ill effects of the efficacy-equity trade-off: this is, only if unnecessary sickness and premature death don't matter can inegalitarian systems ever be considered efficacious (Farmer, 2003: 19)." The struggle for equity is a recurring theme in Farmer's work and a motivating force in his actions. Farmer and the organization he co-founded, Partners in Health, have established projects among impoverished populations throughout the world, including Peru, Russia, and most prominently in Cange, Haiti. These projects deal primarily with the treatment of infectious diseases such as tuberculosis and HIV. Farmer describes a tuberculosis initiative in one of his recent books:

> "Those diagnosed with tuberculosis who participated in the new treatment program were to receive daily visits from their village health worker during the first month following diagnosis. They would also receive financial aid of thirty dollars per month for the first three months; would be eligible for nutritional supplements; would receive regular reminders from their village health worker to attend the clinic; and would receive a five-dollar honorarium to defray "travel" expenses (for example, renting a donkey) for attending the clinic. If a patient did not attend, someone from the clinic – often a physician or an auxiliary nurse – would make a visit to the no-show's house. A series of forms, including a detailed initial interview schedule and home visit reports regularized these arrangements and replaced the relatively limited forms used for other patients (Farmer, 2003: 149-150)."

He goes on to describe the success of the program in curing these individuals, and uses this example to argue that providing high-quality medical services for life-threatening diseases in the context of extreme poverty is both feasible and desirable.

Throughout his writings, Farmer describes the illnesses of individuals he has encountered or treated. These include the story of a young woman whose family was displaced by the construction of an American-designed hydroelectric dam – the family's ensuing poverty forced her to seek out domestic work in the capital and led her to enter a sexual relationship with a man from whom she contracted HIV. Another vignette is that of a young man whose complaints about the conditions of local roads were interpreted as anti-government sentiment during a period of military rule. As a consequence, he was beaten and tortured, and died of his wounds shortly after. Farmer makes a convincing point: virtually any case of suffering or illness in Haiti can be understood as a consequence of poverty, the legacies of slavery and colonialism, and continued exploitation by international forces.

Although Farmer describes his trajectory from Harvard to Haiti in rough detail, he does not provide anthropological perspectives or analyses of the social processes that accompany and result from his own work. Given the size and scope of Partners in Health's projects, it is safe to assume that they have had major impacts on the lives and

societies where the group is active, particularly when one considers the paucity of resources in settings like Haiti. None of the complications that emerge from efforts to treat patients in Haiti: triage of patients, implementation of care, dealing with staff turnover and burnout, or confronting local politics and bureaucracies receive attention in Farmer's writing. In considering the tuberculosis program described above, for example, many questions emerge. How is the project funded? Who are the village health workers and how are they selected? What relationship do they have with other individuals in the community? Is their work renumerated? What exactly happens when a physician or auxiliary nurse visits a "no-show's" house? Other anthropologists have described the conflicts and tensions between health care providers and patients in Haiti (Brodwin: 1996, Maternowska n.d.). It is unlikely that such conflicts and tensions are absent from Farmer's practice.

In addition, Farmer tends to give a one-dimensional portrait of the population he describes. Although the majority of Haitians do live in dire poverty, there are degrees of class stratification within and among the poor. These are reinforced through the activities of the Haitian diaspora in the United States and Canada, who send remittances to family members in Haiti, remain involved in Haitian politics and continue to sponsor emigration. Also, Farmer makes little mention of other foreign aid projects, medical and other, that are active in great numbers throughout Haiti. These projects include hospitals, clinics, medical missions, donations, and education campaigns from the United States, Canada, Cuba, Europe and increasingly, Asia. These groups vary in size, strategy and activity, and some have been active in Haiti for decades. Although their impact is limited by the scope of the demand for medical services in Haiti, their work has a significant impact on the health of the country's population.

These reflections are not intended to discredit Farmer's work. My own perspective on the health and social justice framework is that it is a compelling, effective, and worthy approach to health care among impoverished populations. However, Farmer's work would benefit from consideration of the processes and practices through which health care for the poor is implemented. As it currently stands, it tells us little about the ways in which providers, patients and communities respond to health interventions that shape their lives. I would venture to guess that Farmer's political agenda (to provide health services to patients in need) precludes his capacity or willingness to provide an anthropological analysis of international medical assistance. He may fear that resources for his projects would be diminished or withheld if funders and supporters were to ascertain the tensions, complexities, and failures that are bound to accompany any international aid project. This well-founded fear reflects negatively on the will of wealthy governments and societies to commit to acting in lasting solidarity with the world's poor. Indeed, the very fact that both Farmer's clinical practice and intellectual framework are considered innovative and are even necessary at all speaks poorly for the global politics of inequality, injustice and inhumanity.

As someone who has been influenced by Farmer since the beginning of my academic career, and as a medical anthropologist working in Haiti, I am compelled to examine this body of work in relation to my own. As mentioned above, Farmer's work strikes me as a prime example of the increasing overlap and intensified relationship between humanitarianism and human rights. Both rhetorics are prominent in Farmer's work, who uses human rights rhetoric unproblematically in what can be interpreted as a classic humanitarian project – the provision of assistance to the poor and suffering. (It is interesting to note the frequency with which religious metaphors [particularly that of

sainthood] are used by commentators to describe Farmer's work.) In Farmer's case, the form of assistance (medical services) is particularly salient – Farmer draws frequently on his status as a physician to reinforce his claims and justify his perspectives. Doing so serves his agenda of convincing readers of the feasibility and desirability of treating poor patients. Partners in Health's success has not gone unnoticed – the health and social justice approach has become a model for international health projects who recognize its efficacy both in treating patients and garnering support. Consequently, it is a model that I plan to continue examining in future research.

Reflections on the place of compassion in both human rights and humanitarian rhetorics offer further insight into links between the two. The philosopher Martha Nussbaum has called compassion the "basic social emotion," and argues that it is, "a central bridge between the individual and the community; it is conceived of as our species' way of hooking the interests of others to our own personal goods (Nussbaum, 1996: 28)." She makes the following claims about compassion and justice:

> "[Compassion] is not sufficient for justice, since it focuses on need and offers no account of liberty, rights, or respect for human dignity.... [...] Although compassion does presuppose that the person does not deserve the (full measure) of the hardship he or she endures, it does not entail that the person has a *right* or a just claim to relief. Further argument would be required to get to that conclusion. On the other hand, compassion at least makes us see the importance of the person's lack, and consider with keen interest the claim that such a person might have. In that sense it provides an essential bridge to justice (Nussbaum, 1996: 37)."

The relationship Nussbaum identifies between compassion and justice (and by extension, to humanitarianism and human rights), however, does not eliminate the difference between the two rhetorics. While compassion may be a motivating factor for human rights activists and institutions, it is not as central as in humanitarian rhetoric. Compassion implies a shared suffering, whereas human rights rhetoric, with its

individualizing rhetoric, makes separations between victims, perpetrators, and advocates. Some activists are working to eliminate these distinctions – when human rights workers claim that the violation of a person's rights threatens the rights of all people, they are promoting notions of collectivity and mutual suffering. The need to verbalize and promote this argument suggests that it is not inherent to individualizing human rights discourses. A sense of collectivity and social obligation is not only central to humanitarian conceptions of human relations; it is the impetus for action. Another distinction is that human rights are deployed in a pre-emptive fashion – even in the absence of rights violations, human rights workers can operate for the promotion of rights, their dissemination and protection. Humanitarian activity, on the other hand, is restricted to *responses* to suffering and misery. In the absence of these, humanitarian activities are moot.

While I have taken care to situate my discussion within a particular social, geographical and temporal context, many of the issues discussed here are applicable in other settings, and would benefit from additional research. I would like to briefly discuss three of the themes that have emerged from my research that would benefit from further anthropological analysis. They are the classification of "emergencies" and states of exception; emerging forms of governance and power by international and multinational organizations; and the role of anthropology in making sense of conflicting and contradictory accounts.

The classification of a medical condition as an emergency by hospital staff can be thought of as the deployment of a "state of exception," as described in the writings of political theorists Carl Schmitt and Giorgio Agamben. Perhaps as a cue for further work on the subject, Agamben writes at the end of his text *Homo Sacer*, "[T]oday's

democratico-capitalist project of eliminating the poor classes through development not only reproduces within itself the people that is excluded but also transforms the entire population of the Third World into bare life (Agamben, 1998:180)." While Agamben's concepts should not be transplanted indiscriminately from one setting to another, they can offer insight into the relationships between life and power. Agamben has drawn heavily from Schmitt, who opens his *Political Theology* by stating, "Sovereign is he who decides on the exception (Schmitt, 1985: 5)." Agamben has used Schmitt's theories in his project to further Foucault's analysis of biopolitics. The state of exception, Agamben argues, is becoming "the permanent structure of juridico-political de-localization and dis-location." Emergencies in this perspective are no longer temporary situations, but increasingly common as a normal state of affairs. While Schmitt's and Agamben's theories refer to relatively abstract entities ("the state," "the sovereign") or to historical events (the Holocaust), situating them within the context of contemporary ethnography gives these theories new dimensions and depth. One can identify emergencies and states of exceptions at various levels in Haitian-Dominican relations. Many Dominicans consider the presence of Haitians in their country to be dangerous threat that requires urgent action. Haiti itself is repeatedly described as a prolonged humanitarian crisis by international observers. And finally, when Haitians seek out health care in Dajabón, their cases must be declared emergencies by medical personnel in order to receive treatment, thereby creating a relationship of sovereign and subject between provider and patient. As described earlier, however, practitioners sometimes normalize urgent or critical medical situations (paralysis, dehydration) in order to justify refusing services.

Situating Agamben's work in the context of my research also exposes some of its limitations. When Agamben states that when the state of exception coincides with the

normal order, "everything again becomes possible (Agamben, 1998: 38)," his tone is ominous and foreboding, but in the Haitian-Dominican case, the possibilities may include increased access to resources that are unavailable in the normal order. Anthropologists and political scientists have provided compelling accounts of resistance by disadvantaged and oppressed people. My research indicates that Haitians exercise agency and, despite arduous conditions, have developed strategies for seeking out opportunities for obtaining health care. Agamben's descriptions of "bare life" do not leave room for agency or strategizing on the part of those deemed unfit to live. It is important to distinguish between "bare life" as a condition that agents attribute to or impose on others, and as a phenomenon in and of itself. Examples of the former are numerous and widespread, while cases of the latter are more difficult to identify and often the subject of debate (for example, brain death). Agamben does not distinguish between the two, which hinders more nuanced debates and analysis of the subject.

While Agamben's analysis focuses heavily on the presence of a formal state, the decline of the nation-state in the latter half of the 20th century has been described by political scientists and theorists. This has been accompanied by a rise in the circulation of global capital, the privatization of formerly public industries, and the rise in multi-national corporations. Simultaneously, there has been a marked increase in the number and activities of non-governmental organizations of all kinds, at local, national, and international levels. Scholars have examined the mandate and work of these organizations within the context of new studies on power and government. I have mentioned Pandolfi's work on humanitarian groups, but these make up only one category of organization whose presence is transforming the world's geo-political and bio-political landscapes. Human rights groups, development organizations, environmental protection

groups, evangelical missionary groups... these and many other bodies have come to occupy increasingly important roles in the social and political lives of the communities in which they work, often while maintaining that they are "apolitical." These groups often have indefinite mandates and ambiguous mandates, appointed rather than elected leaders, and extremely complex relationships with their target populations.

Critical analyses of these groups and their work have been remarkably absent from research on Haiti, despite the fact that the country has an extremely high number of NGOs and IGOs working there. These groups work in every imaginable sphere of public life: education, housing, economy, politics, and health care. Their presence underlines the complex and conflicted relationship between agents of the Haitian state and the country's population. When present, the agents of the Haitian state (ministers, officials, police, military) have historically worked against the interest of the people – taxing, exploiting, and terrorizing them. Michel-Rolph Trouillot has written eloquently on the relation between the Haitian state and the Haitian nation, describing how ordinary Haitians have come to disparage, resent, or fear their government. In his work *Haiti: State Against Nation,* he describes the historical precedents leading to the Duvalier dictatorship (1957-1986), and the ways in which state apparatus, in the form of the army, paramilitary groups, and police, have been "pitted against the nation (Trouillot, 1990: 163)." In Trouillot's analysis, "the peasantry *is* the nation (230),"[5] and they have suffered enormously at the hands of their leaders. Oftentimes, however, the state is missing or absent from most spheres of daily life. Much of the infrastructure and resources that are generally considered to be the state's responsibility: roads, schools, health care, environmental regulation, and sanitation are nowhere near adequate. During my research,

[5] I would include the urban poor in this definition.

I frequently heard individuals complain *"Leta pa fè anyen pou nou"* (The state does nothing for us). New projects and emerging infrastructure in Haiti are often the result of projects by international aid organizations: vaccination campaigns, water purification systems, building renovations, and health clinics. Future work is needed to understand the social relations and forms of governmentality that emerge out of this aid, which is widespread throughout the country and has had major impacts on social life at every level. Such work will be particularly important given recent political instabilities in Haiti and the current multi-national mission responsible for maintaining order there.

Finally, it has become clear to me over the course of writing this thesis that anthropological perspectives are useful in helping sort through the conflicting and contradictory perspectives that characterize social interactions. Over the course of my fieldwork, I often witnessed clashing and inconsistent behaviors and accounts, often presented by a single individual. The following case is an example of such an instance. One morning at the border hospital, I met a woman named Marlèn who was waiting for a low-cost sonogram offered by the SSM. Marlèn was 35, and was 8 months pregnant with her 8th child. It had taken her over a day to come to the hospital from a small hamlet in the mountains of Haiti near the Dominican border. She had fainted in church two days before, and had been brought to the hospital by her brother, a frequent migrant who spoke fluent Spanish. She had received a small sum of money from her husband to make the trip, and was exhausted and frightened. She was experiencing extreme pains that left her prostrate on the ground, but was certain that these were not contractions. She was also urinating, hemorrhaging and vomiting blood. The sonographer informed Marlèn that she had lost a good deal of amniotic fluid, and that her fetus was at risk. She felt that the loss of blood was not related to the pregnancy, but said that Marlèn would have to consult a

doctor to be certain. Marlèn decided that she would leave to hospital. She expressed fear that the staff would force her to give birth at 8 months, which she had heard was dangerous for the child.

Overall, Marlèn was very unhappy with the treatment she had received during her two days at the hospital. She said, "Even if I get sick again, I'm not coming back here. I'd rather die in Haiti!" She complained that while interned, she had been left on the ground, and was unable to get to the bathroom. She also complained about the hospital not giving her food. The technician and other nurses explained that it was dangerous to leave, but she was determined to go. When the staff told her that she might lose the baby, and she responded, "*M'mèt pèdi'l* [I can lose it]." I asked her gently if she wanted this baby, and she said yes, but that she would accept God's will, and wished to return home. Unable to sign her name, she made three crosses on a discharge form. Her brother, observing with disapproval, berated her, "Now you've done! You'll never be able to come back here again." "What?" Marlèn asked. The panic in her eyes was obvious. "They won't let me come back? I can't come back here?"

Out of context, Marlèn's behavior seems irrational, the confusion of a sick, ignorant woman. Why, in the span of a few minutes, would she go from asserting that she would rather die in Haiti than return to this hospital to panicking when hearing that she would not be allowed back? I hope that the material presented above will support my argument that there is no contradiction here, rather, the complex and multi-layered response that any person would face in similar circumstances. I have no reason to doubt Marlèn's account of the poor treatment she had received in the hospital. Such treatment is to be expected, in fact, much worse is often reserved for Haitian patients. Marlèn may have been hoping that her depiction of the injustice would garner my sympathy or

assistance, or she may simply have been positioning herself morally in a complex setting. And when informed that she would be unable to return to the hospital, she reacted as anyone in her situation would – with dismay that one of her few medical options was being taken away from her.

Works Cited

Adams, Vincanne. 1998. "Suffering the Winds of Lhasa: Politicized Bodies, Human Rights, Cultural Difference and Humanism in Tibet." In Medical Anthropology Quarterly 12(1): 74-102.

Agamben, Giorgio. 1998 (1995) *Homo Sacer: Sovereign Power and Bare Life.* Translated by Daniel Heller-Roazen. Stanford: Stanford University Press.

Arnold, David. 1993. "Medicine and Colonialism" in *Companion Encyclopedia of the History of Medicine.* W.F. Bynum and Roy Porter, eds. Routledge: London. 1393-1416.

Bobbio, Norberto. 1996 (1990) *The Age of Rights.* Translated by Allan Cameron. Cambridge: Polity Press.

Boisseron, Monique. 2000. « Haïti dans le regard de la République Dominicaine dans la seconde moitié du XXième siècle » Doctoral thesis, Université des Antilles et de la Guyane.

Cayemittes, Michel, M.F. Placide, B. Barrère, S. Mariko, B. Sévère. 2001. *Enquête Mortalité, Morbidité et Utilisation des Services, Haïti 2000.* Calverton, Maryland USA : Ministère de la Santé Publique et de la Population, Institut Haïtien de l'Enfance and ORC Macro.

Chavez, Leo R., Estevan T. Flores, Marta Lopez-Garza. 1992. 'Undocumented Latin American Immigrants and U.S. Health Services: An Approach to a Political Economy of Utilization." In Medical Anthropology Quarterly (6)1: 6-26.

Chierici, Rose-Marie. N.d. Personal communication.

Daudelin, Jean and Lee Seymour. 2002. « Ingérence humanitaire et "Responsabilité de protéger": Au-delà du droit et des bonnes intentions. » In *L'action humanitaire du Canada.* Yvan Conoir and Gérard Verna, eds. Laval : Université Laval. 157-181.

Davies, Oliver. 2001. *A Theology of Compassion: Metaphysics of Difference and the Renewal of Tradition.* London: SCM Press.

Dembour, Marie Bénédicte. 1996. "Human rights talk and anthropological ambivalence: the particular contexts of universal claims." in *Inside and Outside the Law: Anthropological Studies of Authority and Ambivalence.* Olivia Harris. ed. London: Routledge.

Diskett, Patricia and Patricia Nickson. 1997. "Financing Primary Health Care: An NGO

Perspective." In *Development for Health.* Deborah Eade, ed. Oxford: Oxfam. 73-79.

Donnelly, Jack. 2003. *Universal Human Rights in Theory and Practice.* Ithaca: Cornell University Press.

Echavé, Vincent and Marie-Hélène Chomienne-Abboud. « Mutations dans l'aide humanitaire. » In *L'action humanitaire du Canada.* Yvan Conoir and Gérard Verna, eds. Laval : Université Laval. 100-119.

Farmer, Paul. 1992. *AIDS and Accusation: Haiti and the Geography of Blame.* Berkeley: University of California Press.

Farmer, Paul. 1994. *The Uses of Haiti.* Monroe: Common Courage Press.

Farmer, Paul. 2003. *Pathologies of Power : Health, Human Rights and the New War on the Poor.* Berkeley: University of California Press.

Foucault, Michel. 1976. *Histoire de la sexualité I: La volonté de savoir.* Paris : Gallimard.

Foucault, Michel. 1963. *Naissance de la clinique.* Paris : Presses Universitaires de Paris.

Franco, Franklin J. 1973 "Antihaitianismo e ideología del Trujillato." In *Problemas dominico-haitianos y del Caribe.* Gérard Pierre-Charles et al. eds. Mexico City: National Autonomous University of Mexico.

Gorman, Jonathan. 2003. *Rights and Reason: An Introduction to the Philosophy of Rights.* Montréal and Kingston: McGill-Queen's University Press:

Godbout, Jacques T. with Alain Caillé. 1998. *The World of the Gift.* Trans. Donald Winkler. Montréal: McGill-Queen's University Press.

Guerrero, Ernesto. N.d. Personal communication.

Haidt, Jonathan. 2003 "The Moral Emotions." In *Handbook of Affective Sciences.* Richard J. Davidson et al., eds. Oxford : Oxford University Press. 852-870.

Herbert, Gary B. 2002. *A Philosophical History of Rights.* New Brunsick: Transaction Publishers.

Howard, David. 2001. *Coloring the Nation: Race and Ethnicity in the Dominican Republic.* Oxford: Signal Books Limited.

International Human Rights Law Clinic. 2002. *Unwelcome Guests: A Study of Expulsions of Haitians and Dominicans of Haitian Descent from the Dominican Republic to Haiti.* Berkeley: University of California, Berkley School of Law.

Isaac, Ephraim. 1993. "Humanitarianism Across Religions and Cultures." In *Humanitarianism Across Borders: Sustaining Civilians in Times of War.* ThomasG. Weiss and Larry Minears, eds. Boulder: Lynne Reimer Publishers.

Jones, Colin. 1993. "Charity Before 1850." In *Companion Encyclopedia of the History of Medicine.* Volume 2. W.F. Bynum and Roy Porter, eds. Routledge: London.

Lemoine, Maurice. 1981. *Sucre amer: esclaves d'aujourd'hui dans les Caraïbes.* Paris : Encre.

López Severino, Irene, de Moya, E. Antonio. 2000 "Rutas migratorias de Haití a República Dominicana: Implicaciones para el VIH/SIDA y los Derechos Humanos de las personas infectadas." Santo Domingo : Patronato de Lucha contra el SIDA, Inc.

Logan, Rayford W. 1968. *Haiti and the Dominican Republic.* London: Oxford University Press.

Martinez, Samuel. 1995. *Peripheral Migrants: Haitians and Dominican Republic Sugar Plantations.* Knoxville: University of Tennessee Press.

Martinez, Samuel. 1996. "Indifference Within Indignation: Anthropology, Human Rights and the Haitian Brecero." In American Anthropologist 98(1). 17-25.

Maternowska, Catherine. N.d. *Of Coups d'États and Contraceptives: Political Economy and Family Planning in Urban Haiti.* Unpublished manuscript.

Mburu, F. and Boerma, J. 1989 "Community-based Health Care 10 Years Post Alma Ata." In *Social Science and Medicine* 28(10):1005-6.

Messer, Ellen. 1993. "Anthropology and Human Rights." In Annual Review of Anthropology, 22. 221-249.

Minear, Larry. 2002. *The Humanitarian Enterpreise: Dilemmas and Discoveries.* Bloomfield: Kumarian Press.

Moore, Erin. 1986. "Issues in Access to Health Care: The Undocumented Mexican Resident in Richmond, California." in Medical Anthropology Quarterly 17(3): 65-70.

Morgan, Lynn M. 1993. *Community Participation in Health: The Politics of Primary Care in CostaRica.* Cambridge: Cambridge University Press.

Myers, Fred R. 1986. *Pintupi Country, Pintupi Self: Sentiment, Place, and Politics among WesternDesert Aborigines.* Washington and London: Smithsonian Institution Press.

Navarro, Vicente. 1984. "A Critique of the Ideological and Political Positions of the Willy Brandt Report and the WHO Alma Ata Declaration." In Social Science and Medicine 18(6): 467-474.

Nussbaum, Martha. 1996. "Compassion: The Basic Social Emotion." In Social Philosophy and Policy 13(1). 27-58

O'Keefe, Phil, Ted Kliest, John Kirby and Wiert Flikkema. 1993. "Somalia: Towards Evaluating the Netherlands' Humanitarian Assistance." In *Evaluating International Humanitarian Action: Reflections from Practitioners.* Wood, Adrian, Raymond Apthorpe and John Borton, eds. London: Zed Books. 19-38.

Osteen, Mark. 2002. "Introduction: Questions of the Gift." In *The Question of the Gift : Essays Across the Disciplines.* Mark Osteen, ed. London: Routledge.

Pandolfi, Mariella. 2002 « "Moral Entrepreneurs " : Souverainetés mouvantes et barbelés : Le biopolitique dans les Balkans postcommunistes." In Anthropologie et Société 26 (1).

RESAL (Réseau européen de sécurité alimentaire). 2001. « Appréciation des échanges cmmerciaux agricoles transfrontaliers entre la République Dominicaine et Haïti. » Louvain-la-Neuve : ADE.

Renteln, Alison. 1988. "Relativism and the Search for Human Rights." In American Anthropologist 90: 64.

Roemer, Milton I. 1993 "Internationalism in Medicine and Public Health" in *Companion Encyclopedia of the History of Medicine.* W.F. Bynum and Roy Porter, eds. Routledge: London. 1417-1435.

SESPAS (Secretaría de Estado, Salud Publica y Asistencia Social). 2001. "Incidencia de la Demanda de Servicios de Salud de Extranjeros." Santo Domingo : SESPAS.

Schmitt, Carl. 1985 (1922) *Political Theology : Four Chapters on the Concept of Sovereignty.* Translated by George Schwab. Cambridge : MIT Press.

Sen, Amartya. 1999. *Development as Freedom.* New York: Anchor Books.

Silié, Rubén and Carlos Segura. 2002a. *Una isla para dos.* Santo Domingo : FLACSO.

Silié, Rubén, Carlos Seguar and Carlos Dore Cabral. 2002b. *La Nueva inmigración haitiana.* Santo Domingo: FLACSO.

Simmons, David. N.d. Personal communication.

St Pierre, Monique. 2002. « L'ingérence humanitaire : une brève histoire. » In. *L'action*

humanitaire du Canada. Yvan Conoir and Gérard Verna, eds. Laval : Université Laval. 45-58.

Stambolovic, Vuk. 1996. "Editorial: Human Rights and Health Within the Dominant Paradigm." In Social Science and Medicine (42) 3, 301-303.

Titmuss, Richard. 1970. *The Gift Relationship: From Human Blood to Social Policy.* London: George Allen and Unwin Ltd.

Trouillot, Michel-Rolph. 1990. *Haiti, State Against Nation: The Origins and Legacy of Duvalierism.* New York: Monthly Review Press.

Vaux, Tony. 2001. *The Selfish Altruist.* London: Earthscan Publications.

Wilson, Richard A. 1997. "Human Rights, Culture and Context: An Introduction." In *Human Rights, Culture And Context: Anthropological Perspectives.* Wilson, Richard A. ed. London: Pluto. 1-27.

Wittgenstein, Ludwig. 1953. *Philosophical Investigations.* Oxford: Basil Blackwell.

Wood, Adrian, Raymond Apthorpe and John Borton. 1993. *Evaluating International Humanitarian Action: Reflections from Practitioners.* London: Zed Books.

Wucker, Michelle. 1999. *Why the Cocks Fight: Dominicans, Haitians, and the Struggle for Hispaniola.* New York: Hill and Wang.

Websites:

http://www.one.gov.do

http://www3.who.int/whosis/hale

http://untreaty.un.org/English/guide.asp

McGill

Research Ethics Board Office
McGill University
845 Sherbrooke Street West
James Administration Bldg., rm 429
Montreal, QC H3A 2T5

Tel: (514) 398-6831
Fax: (514) 398-4853
Ethics website: www.mcgill.ca/rgo/ethics/human

Research Ethics Board I
Certificate of Ethical Acceptability of Research Involving Humans

Project Title: Social and Cultural determinants of Health Among Haitian Laborers on Dominican Sugar Plantations

Applicant's Name: Pierre H. Minn **Department**: Anthropology

Status: Master's student

Supervisor's Name (if applicable): Dr. A. Young

Granting Agency and Title (if applicable): Internal SSHRC; McGill Society for Technology and Development (pending)

This project was reviewed on April 8, 2003 by

Expedited Review ____
Full Review ✓

Signature/Date 8/04/03

John Galaty, Ph.D.
Chair, REB I

Approval Period: April 8, 2003 **to** April 7, 2004

REB File #: 534-0403

cc: Anthropology Dept.
Dr. A. Young