# "Where They Need Me": The Moral Economy of International Medical Aid in Haiti

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**Abstract**

This dissertation examines and analyzes the provision of international medical aid in northern Haiti. Medical aid in this setting comprises a wide range of goods and services, including pharmaceutical supplies and medical equipment, clinical procedures, support for infrastructure projects and training for Haitian medical staff. Based on ethnographic research conducted from 2007 to 2009 among the providers, implementors and recipients of medical aid, this study examines the various collaborations and tensions that result from the provision of health resources across marked social and economic inequalities. Beginning with a discussion of humanitarian heroism as exemplified by the lives and work of Drs. Albert Schweitzer and Paul Farmer, the dissertation goes on to describe the activities of a secular U.S.-based health NGO. The third chapter is devoted to the experiences and perspectives of Haitian medical residents at a large, public hospital, situating their lives and work within larger debates about obligation and emigration. The fourth chapter focuses on the issue of coordination, and examines the factors that impede coordination among the diverse actors involved in medical aid, despite unanimous calls for it. The final chapter proposes theories of moral economy, resentment and *ressentiment* as frameworks for understanding the diverse exchanges, values and emotions that constitute, influence and result from medical aid encounters. Rather than expose the shortcomings or failures of international medical aid in Haiti, this dissertation aims to highlight the ambivalence and contradictions experienced by the diverse actors involved in this complex process.

## Résumé

Cette thèse porte sur l'aide médicale internationale dans le nord d'Haïti. L'aide

Cette thèse a pour objet d'étudier et d'analyser l'assistance médicale internationale déployée dans le nord d'Haïti. Dans ce contexte, l'assistance médicale englobe un large éventail de biens et de services, notamment les fournitures pharmaceutiques et les équipements médicaux, les procédures médicales, le soutien aux projets d'infrastructures ainsi que la formation du personnel médical. Fondée sur des recherches ethnographiques menées de 2007 à 2009 auprès de fournisseurs, de metteurs en oeuvre et de bénéficiaires d'assistance médicale, la présente étude examine les différentes relations de collaboration et les tensions qui découlent de la prestation de services de santé dans un milieu caractérisé par des inégalités sociales et économiques marquées. Après une discussion sur l'héroïsme humanitaire, qui est ici illustré par la vie et les travaux des médecins Albert Schweitzer et de Paul Farmer, cette thèse examinera les activités d'une ONG de santé laïque des États-Unis. Le troisième chapitre est consacré aux expériences et aux points de vue de médecins haïtiens résidents qui oeuvrent dans un grand hôpital public, situant la vie et le travail de ces derniers dans le cadre de grands débats sur les obligations et l'émigration. Le quatrième chapitre examine les facteurs qui entravent la collaboration, pourtant réclamée de toutes parts, entre les différents intervenants des services d'assistance médicale. Le dernier chapitre propose des théories fondées sur l'économie morale et le ressentiment en tant que cadres conceptuels pour comprendre les échanges, les valeurs et les émotions de nature variée qui constituent et influencent les rencontres entre les intervenants de l'assistance médicale, et qui naissent de celles-ci. Plutôt que d'exposer les faiblesses ou les défaillances de l'assistance médicale internationale en Haïti, cette thèse vise à mettre en lumière l'ambivalence et les contradictions vécues par les divers acteurs engagés dans ce processus complexe.

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DEDICATION

This dissertation is dedicated to Anne-Rose “Rosie” Toussaint:

teacher, mentor and friend in Nan Sab, Haiti.

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# Introduction

This dissertation is the study of a transnational process: the provision of international medical aid to health establishments and individuals in Haiti. While ethnographic monographs have traditionally described populations selected on the basis of locality or identity, this study analyzes the individuals, relationships and institutions involved in a dynamic social phenomenon. Although geography played an important role in shaping the contours of this research, bringing into relief specific sites in Haiti, the United States, Canada and elsewhere, international medical aid by its very definition involves the movement of diverse resources across disparate localities. Therefore, this work responds to a call for multi-sited ethnographies (Marcus, 1995) that follow the circulation of people, objects and ideas across time and space. This approach is especially suited to studies that involve the Caribbean, which scholars have identified as an early site of globalization because of how the region has been shaped by the forces of empire, colonization and migration (Mintz, 1986; 2007). More specifically, Haiti is a particularly salient example of how seemingly isolated and remote populations are affected by events and processes that take place in distant nations (Farmer, 1991; 1992). In addition to building on and adding to a considerable body of anthropological literature on Haiti, this dissertation addresses established themes in medical anthropology (sickness, healing and medicine) and also contributes to an emerging anthropology of humanitarianism.

Anthropologists writing on Haiti have long made use of history to help explain the social phenomena they observe and analyze. Michel-Rolph Trouillot (1992) attributes this to Caribbean societies being "inescapably historical, in the sense that some of their distant past is not only known, but known to be different from their present, and relevant to both the observers' and the natives' understanding of that present (21)." Regional "gatekeeping concepts," the "so-called 'native' traits mythified by theory in ways that bound the object of study" have not been successful in the Caribbean, where an awareness of colonialism and contact have made such concepts untenable.[1] Anthropological works on Haiti have ranged from early works on folklore and rural life (Price-Mars, 1938; Courlander 1960; Leyburn, 1941; Moral, 1961; Herskovitz, 1971) and Vodou (Métraux, 1958; Deren, 1953), to more recent studies that broaden the scope of analysis to include migration and transnationalism (Brown, 2001; Glick Schiller and Fouron, 2001; Richman, 2005; McAlister, 2002.) Works by medical anthropologists in recent years have examined violence, trauma and insecurity in the context of post-Duvalier political instability (James, 2010); morality, healing and medical pluralism (Brodwin, 1996); HIV and social suffering (Farmer, 1992); and family planning and fertility (Maternowska, 2006).

This dissertation draws on existing anthropological literature on Haiti and its attention to history in that it frames the conditions I encountered during my fieldwork as the results of specific historical processes and configurations. I am particularly interested in the contemporary manifestations of medical aid practices

[1] Trouillot gives hierarchy in India and honor/shame in the Mediterranean as example of these gatekeeping concepts.

that have precedents in different forms in Haitian history. (I also understand the phenomena I describe to be in a state of constant change and flux – the dramatic events of 2010 highlight the ruptures that result from catastrophes, epidemics and other events.) In addition, this dissertation builds on an area of enduring interest to scholars of Haiti: morality and ethics in a context of resource scarcity, competing pressures, and strained social relations. It expands the scope of these analyses by examining Haitian-foreign aid encounters, encounters that have become increasingly common since the second half of the 20th century.

The anthropology of humanitarianism is a field that has seen substantial growth in recent years. I have identified this field as emerging from the confluence of diverse but related interests: international development, refugee studies, medical anthropology and political anthropology (Minn, 2007). Work on international development, a well-established topic among anthropologists, is diversifying in its purpose and focus, and has given way to debates that are particularly relevant to the study of humanitarianism. For example, Ferguson's (1994) influential study of what he labeled the depoliticizing practices of an "anti-politics machine" has been critiqued by Mosse (2005), who wishes to "reinstate the complex agency of actors in development at every level, and to move on from the image of duped perpetrators and victims…(5-6)." Authors have examined different manifestations and facets of development: Bornstein's 2003 study of Protestant Christianity and NGOs in Zimbabwe grew out of what appeared to her as a contradiction between Christianity and development. She concludes that in

fact, the two are not antithetical, and that religion, politics and development should not necessarily be divided into discrete realms. She writes,

> "Whether Christian development is "good" or not is not the question at issue here. Rather, one might ask: how does development make things good or not? How does development create moral categories that connect those who help the needy with those who are in need? These relationships, links in the relational economy of humanitarian aid, are expressions of hopes and dreams, and sometimes despair. They are the efforts, products, and contributions of some to change the lives of others, and they are the desires of some to have their lives changed (Bornstein, 2003: 177)."

Bornstein's study highlights the overlap and convergences between development and humanitarianism as objects of study. This mirrors the empirical observations from various fieldsites where it can often be difficult to distinguish between short-term aid and long term development (Anderson, 1993). Mindry (2001), examining the work of development NGOs in South Africa, points to the importance of recognizing the political effectiveness of these groups and their ability to "use networks to situate themselves strategically to take advantage of opportunities to access funding and resources (1204)." The author describes the "hierarchies of virtue" that are at present in how developing countries are imagined, and calls for further investigations of the "moral politics" of virtue, asking "How is virtue deployed as a means of exercising power (1205)?" The issue of moral politics is central to humanitarian activity, as is the construction of worthy recipients through essentialized categories: the sick, the poor, or in the case of Malkki's work, refugees. Her research in the Great Lakes region of Africa has described how the provision of relief and assistance is accompanied by "other, unannounced social processes and practices that are dehistoricizing (Malkki, 1996: 378)." To better understand these processes, Malkki's analysis examined the "contingent sociohistorical processes of making and unmaking categorical

identities and moral communities (Malkki, 1995: 17)," and considered the state of "refugee-ness" as important an object of study as the refugees themselves.

Medical anthropologists with an interest in humanitarianism include Peter Redfield, whose work on MSF describes what he calls its "minimalist biopolitics." For Redfield, MSF's work "is not simply an analogy to that of a state agency insofar as it avoids wider governance and its inherent mobility produces only partial and limited effects of sovereignty and citizenship (Redfield, 2005: 330-331)." Redfield aims to "move away from treating humanitarianism as an absolute value by approaching it as an array of particular embodied, situated practices emanating from the humanitarian desire to alleviate the suffering of others (331)." Another medical anthropologist, Didier Fassin, writing on topics ranging from immigration policies in France to the HIV/AIDS epidemic in South Africa, describes humanitarianism as a "politics of life":

> "…politics that give specific value and meaning to human life. They differ analytically from Foucauldian biopolitics, defined as "the regulation of population," in that they relate not to the technologies of power and the way populations are governed but to the evaluation of human beings and the meaning of their existence […] [I]t takes as its object the saving of individuals, which presupposes not only risking others but also making a selection of which existences it is possible or legitimate to save […] And humanitarian intervention is also a politics of life in that it takes as its object the defense of causes, which presupposes not only leaving other causes aside but also producing public representations of the human beings to be defended (e.g., by showing them as victims rather than combatants and by displaying their condition in terms of suffering rather than the geopolitical situation). What sort of life is implicitly or explicitly taken into account in the political work of humanitarian intervention? (Fassin: 2007: 501)"

Another medical anthropologist, Vinh-Kim Nguyen describes the "therapeutic citizenship" and various kinds of triage that are at play in the provision of HIV medications in Côte d'Ivoire and Burkina Faso. His work explores "what forms of politics might emerge in a world where sometimes the only way to survive is

by having a fatal illness. It is a politics where the power to save lives is as important as the power to inflict bodily harm or kill (Nguyen, 2010: 6)." Analyzing the complex relations between patients, research, national health care structures and international agencies, Nguyen's account highlights the importance of local histories in understanding broader, global phenomena.

It is important to note that anthropologists working on humanitarianism and issues related to it have not drawn from a singular theoretical axis. Rather, certain thematic interests have emerged in recent works, including sovereignty, intervention, biopolitics, transnationality, and ethics. A particularly interesting development to follow in the coming years will be the relationship that develops between the anthropology of humanitarianism and the anthropology of global health, another emerging field with roots in medical anthropology.

Finally, despite its relatively long engagement with questions of health and healing in impoverished areas, the practice of biomedicine by individuals in and from these settings is a relatively recent concern in medical anthropology. While the discipline's earlier topics included ethnomedicine, critical examinations of biomedicine in industrialized countries, and the impact of colonial and globalizing processes on the health of individuals around the world, only in recent decades have medical anthropologists turned their attention to the work of local biomedical clinicians in impoverished settings.[2] Notable studies in this area include Adams' (1998) analysis of the roles health professionals played in the 1990 Nepal revolution, Wendland's (2010) study of medical students and medical

[2] Biomedical professionals working in impoverished settings have long figured in studies on medical pluralism, on the impact of biomedical technologies, or in works on migration and brain drain, however studies of these professionals *per se* are a more recent phenomenon.

practice in Malawi, and Closser's (2010) account of health workers in polio eradication campaigns in Pakistan. My dissertation contributes to this growing body of literature with a specific examination of the experiences and perspectives of Haitian health professionals.

**Methodology and Fieldwork**

I conducted fourteen months of ethnographic research for this dissertation, beginning in the fall of 2007 and ending in the spring of 2009. Prior to this period, I had spent approximately one year in northern Haiti conducting research on health and medical services and volunteering with NGOs. I selected the city of Cap-Haïtien as my primary field site because of my familiarity with the area and my existing network of local contacts. Moreover, I wanted to examine international medical aid in a densely populated urban setting outside the capital of Port-au-Prince, where most urban ethnographies of Haiti have been conducted (see, for example, Kovats-Bernat, 2006; Giafferi-Dombre 2007). This also permitted me to observe the challenges health institutions face in operating outside of the capital in the context of a highly centralized health system.

The bulk of my research took place at the Hôpital Universitaire Justinien (HUJ), a two-hundred-forty bed public hospital located in the heart of Cap-Haïtien. The HUJ is the largest hospital in northern Haiti and the second largest in the country. Founded in 1890 by wealthy citizens of Cap-Haïtien to keep the city's destitute out of public view (Constant, 1967), it was administered by an order of French nuns until the early 1990s, when the order transferred control of

the establishment to the Haitian government. After a series of executive directors, the hospital today is run by an administrative council of seven individuals, and reports to the Haitian Ministry of Health and Population's (MSPP) office in Cap-Haïtien. I received permission from both the hospital's administration and MSPP's northern office to conduct my research at the HUJ.

While at the HUJ, I conducted participant-observaton research with the representatives, employees and volunteers of international medical aid groups and agencies, and with the hospital's Haitian medical staff. When foreign groups were physically present at the hospital, I accompanied them during their activities, which ranged from meetings with the hospital administrators and staff to sitting in on consultations with patients and unloading donated equipment from shipping containers. I also met with the groups at their hotels, joining them for meals and the long discussions that followed their days at the hospital. When foreign teams were not present (and to a lesser extent, even when they were), I followed the activities of the hospital's medical staff, in particular those who worked closely with international programs. I became particularly interested in the work and experiences of the hospital's fifty-four medical residents. These recent graduates of Haitian medical schools in Port-au-Prince were undertaking three to four-year residencies at the HUJ in a variety of medical specialties. I conducted semi-structured interviews with fifty-two of the residents, to gain insight into their relationships with and perspectives on international interventions at the hospital. I also interviewed them about other dimensions of their lives related to

transnationality, including their experiences abroad and their future career plans, which in most cases involved emigration.

In addition to my research at the HUJ, I also traveled to rural field sites in northern Haiti to visit private hospitals and clinics and to follow week-long mobile medical campaigns by visiting foreign teams. These experiences provided contrasting examples and data to the findings from the HUJ, and gave me a better sense of how medical aid operates in diverse forms throughout Haiti. Finally, I conducted research in the American and Canadian cities where selected aid organizations are based, including Portland, Montreal and Memphis. The observations and interviews from these locations gave me insights into how international aid workers and volunteers interpret and give meaning to their work in Haiti in very different contexts, and how they translate situations, encounters and projects from Haiti into narratives and appeals that can reach North American audiences.

When I began my fieldwork, the HUJ's medical and executive directors wrote a notice stating that I would be at the hospital for a prolonged period conducting a study on international interventions, and sent copies to all of the department heads in the institution. I subsequently saw the notice posted on the walls of the various departments next to other official announcements and flyers. This simple act formally legitimated my presence at the hospital and greatly facilitated my presence in the HUJ's offices and clinical spaces. To most people, I was known simply as Pyè, the Canadian student. (Some of the hospital's support staff persisted in calling me "*Dòk*" despite my explanations that I wasn't a

physician.) Because I was often seen in the presence of international aid groups, many people assumed that I was a member of such a group. I did my best to correct this assumption by repeatedly explaining the purpose of my research, by increasing my presence at the hospital after foreign teams had departed, and by taking small actions to distinguish myself from the foreign teams (such as not arriving at or departing from the hospital with them, visibly paying for my meals separately in hotels or restaurants, and sitting or socializing with Haitians when mixed groups divided along national or linguistic lines). As in any field setting, it was impossible for me to determine others' impressions of my identity or purpose: after a few months, some of the hospital staff that I had become friendly with informed me that it was rumored that I was working for the CIA.[3] In the streets of Cap-Haïtien, I was regularly mistaken for a Catholic priest, a Protestant missionary, a Dominican businessman, or a UN worker. When asked, I would state that I was a Canadian student doing research on health care and international aid).

**Selecting Interventions**

Before beginning the research for this study, I was aware of five international bodies providing aid in the HUJ, and assumed that I would encounter a similar number with time. By the time I completed my research, I

[3] "Don't worry," my Haitian friends told me, "they say that about any foreigner who goes around asking questions." They told me that after the hospital administration had succeeded in convincing the city's police force to assign two officers to the hospital (after a series of violent outbursts by relatives of patients who had received unsatisfactory treatment), rumors flew that the police officers were spying on the hospital for the Haitian government. I observed that the officers mostly stayed in their booth near the hospital's entrance and watched television.

had identified thirty-five governmental and non-governmental agencies and organizations that were directly and indirectly providing some form of assistance or support to the hospital, and even more have appeared since I completed my fieldwork. It was apparent even early on during my research that I would be unable to thoroughly investigate all of these sources of aid. Instead, I chose initiatives based on the access I could obtain to informants involved in them, and attempted to select forms of aid that were diverse in their origins, structures and activities. The aid group that I had the most contact with was Konbit Sante, a small American NGO that is active in multiple areas of the hospital. I describe this organization in detail in Chapter 3. Other groups that I had privileged access to include: a team of Dominicans and Americans that travelled to Haiti to provide orthopedic surgeries, an organization of Haitian-Canadians that organized workshops for nursing students and donations of medical equipment for several of the hospital's departments, an American NGO that provided nutritional therapy to malnourished children, and a Florida university-based family medicine residency program for Haitian medical residents that also oversaw the distribution of anti-retroviral medications in the hospital.

Certain organizations were not investigated in depth because of their relatively minor involvement in the hospital (i.e., periodic or one-time donations, etc.) Other agencies worked through the organizations I examined more directly – for example, the Centers for Disease Control partially funded the Florida-based university's work at the HUJ, but were not physically present at the hospital. Some organizations were based in distant locations and difficult to access (such as

a group based in Germany that funded the ophthalmology department). Access to a medical aid initiative was only explicitly denied in one case, that of the Cuban medical brigades.[4]

Most of the groups I focused my attention on were secular in nature. This is due both to circumstance and to a conscious effort on my part. The majority of international aid groups and organizations active at the HUJ were not religiously affiliated. As an officially secular public institution[5], the hospital tends to attract partnerships from large multi-national agencies, national governments, universities, and civic institutions. Religiously-affiliated health establishments in Haiti are much more likely to receive support from international religious bodies such as individual churches, church networks, or religious NGOs. In addition, I was particularly interested in following the work of secular organizations to examine changes in international medical aid in recent decades. While faith-based aid and development initiatives continue to be extremely active in Haiti and elsewhere (Hefferan, 2007; Bornstein, 2005), secular medical aid organizations have increased in prominence in recent years. This is not to claim that the secular groups I studied are not drawing from or influenced by an established Judeo-Christian tradition, or that aid administrators and recipients in Haiti never

[4] The Cubans at the hospital referred me to their local *jefe de brigada* (brigade chief), who referred me to the national leader of the Cuban mission in Port-au-Prince, who said that he would not have any problem with my interviewing members of the Cuban brigades, but would need approval from authorities in Cuba. When I wrote to him subsequently, I received the following response: "The position of the directors of the Cuban Medical Collaboration is to avoid participating in this type of project, as our collaborators must focus their attention only on the provision of medical aid to the Haitian population (my translation)."

[5] The hospital was founded as a Catholic institution, and has a chaplain and functional chapel to this day. The hospital itself, however, is no longer formally affiliated with the Catholic Church, and the chaplain plays only a very minimal role in the hospital's functioning. During the totality of my fieldwork, I never saw him anywhere other than in his private quarters, located directly behind the hospital's rear courtyard.

interpret their secular donors' actions in religious terms. Rather, I was interested in exploring the distinct logics, values and rhetorics that secular organizations draw from and express in carrying out their activities.

**Language**

While Haiti is one of the world's most linguistically homogenous countries (Lewis, 2009), the particularities of its sociolinguistic situation and the added complexity of negotiating transnational encounters warrant a brief discussion of language here. Haitian Creole (*kreyòl ayisyen*) is spoken by 100% of Haiti's population, with the vast majority of Haitians speaking the language as their sole mother tongue, and a small minority of native bilingual Creole and French speakers (Schieffelin and Doucet Charlier, 1994: 178-179). Haitian Creole is thought to have developed in colonial Saint-Domingue during the 17th and 18th centuries (DeGraff, 2002: 386), and while the greatest part of language's lexicon is of French origin, the two languages are not mutually intelligible (Valdman, 2007: iii). For the majority of Haitians (namely those living in the countryside or in densely populated urban areas), Creole is the exclusive means of communication. French is spoken by what many estimate to be less than 15% of Haiti's population, including the country's elite, members of its small middle class, and the few individuals from poorer backgrounds who have received formal education.

During my research, I was often confronted with decisions about which language to use. When meeting monolingual Creole speakers, the choice was

obvious, and my ability to communicate Creole generally garnered positive reactions. With health professionals such as nurses, physicians and administrators, however, speaking in Creole on a first encounter could indicate excessive familiarity, and possibly a lack of respect. In Haiti, formal situations (including initial encounters) often take place in French among those who speak the language, and speakers may switch to Creole when the conversation takes on a more informal tone, or in order to to express oneself in a livelier and more spontaneous manner. I was often told that even those Haitians who speak French fluently are more apt to express strong emotions or personal sentiments in Creole, and I often found that my own conversations or discussions with informants in Creole were more frank, direct, and intimate than those in French. There were some times, however, where I attempted to switch to Creole only to have my interlocutor reply in French, which I interpreted as a cue to return to French. In other situations, individuals with whom I had a Creole rapport would switch into French when a third party arrived, depending on their relationship and degree of formality with that individual.

Because many of the foreigners who work in Haitian medical settings do so for short periods of time, the majority of them do not speak Creole. In addition, individuals who spoke little or no French faced both difficulties in communicating in formal settings (government offices, biomedical settings, etc) and greater challenges in learning Creole than did francophones due to the language's French-based lexicon. In recent decades, however, English has become increasingly prominent as a desirable second language in Haiti (Hoffman,

1990: 288), due in great part to ties with the Haitian diaspora in the United States, North American economic, political and cultural influence, and the weakened presence of France in the daily affairs and imaginations of most Haitians. I encountered many individuals who spoke Spanish – in addition to maintaining ties with the large population of Haitians and Haitian-Dominicans who live permanently in the neighboring Dominican Republic, many Haitians cross the border to conduct commercial activities, work in construction and agriculture, and to study in Dominican institutions. I was frequently addressed in both Spanish and English by strangers in Cap-Haïtien.

My role as an interpreter and translator for in contexts ranging from conversations between individuals to large meetings and seminars not only gave me access to a wide range of encounters that would have been difficult to gain access to otherwise, but also allowed me to provide concrete assistance to the people and organizations I was studying and facilitate their activities. With time, however, I found that I was better able to make observations and take notes when another person was translating. Many of the groups that I observed work with a Haitian medical professional who is multi-lingual, or hire young men specifically for translation services. As I often found myself in the same position as these translators (having to facilitate encounters between Haitian and foreign groups and make decisions about translation that went far beyond linguistic equivalence), we often developed close friendships, and I learned a great deal from watching them negotiate disparate and sometimes contradictory pressures.

**Effectiveness and Exposé**

When I told people in both Haiti and in North America that I was doing a study on international aid, they often made two related assumptions: 1) that my research would be evaluating the effectiveness of international aid; 2) that my research would expose that international aid was ineffective or nefarious. There are two genres of writing that these assumptions correspond to: evaluations of international aid (often carried out or mandated by the organization whose work is being evaluated) and writings by journalists, social scientists and former aid workers on the failures of aid and its incapacity to alleviate poverty and suffering. The former tends to involve quantitative measures related to inputs and outcomes, including sources of revenues and calculations of expenditures, classifications of interventions by number and type, and general information regarding the group's activities that often highlights successes and accomplishments. The second genre is comprised of analyses that tend to critique aid as part of a larger dysfunctional global economic and political system. Authors draw on specific case studies to prove that aid is not doing what its proponents claim it is doing, and moreover, may be worsening the plight of the populations it aims to benefit. Examples of this type include Graham Hancock's *The Lords of Poverty*, David Rieff's *A Bed for the Night: Humanitarianism in Crisis*, and more recently, *Dead Aid* by Dambisa Moyo. These accounts can provide valuable information on the complex world of international aid, and can be instrumental in bringing about reforms in how aid is conceived and carried out. However, exposé accounts of aid failures

are limited in their capacity to analyze and describe the social dimensions of international interventions.

In designing and conducting this research, I have specifically avoided the exposé genre, for a number of reasons. First of all, such a work would be redundant in the context of numerous other works that have taken this approach. The anthropological and intellectual potential of such a project would be limited, given the assumptions that would precede my investigations and the limited theoretical frameworks that would be available for analysis. A strong anthropological study of the diverse relationships, collaborations and conflicts that are involved in international medical aid interventions requires conceptual tools that 1) account for change and nuance, and 2) do not make *a priori* assumptions about the motivations, values and characters of those involved in aid. Finally, I wanted to conduct my research in good faith, letting my primary informants know that my intention was not to seek out their personal faults or moral failings, but rather understand a complicated process with multiple variables, diverse actors, and high stakes. While some individuals may have been wary of my motivations, I found that people seemed to grow more comfortable with my presence over time. The organizations I chose to study in depth for this research were open and generous with their information, allowing me access to their internal documents, permitting me to sit in on meetings and consultations, and allowing me free access to their work spaces.

**Organization of the Thesis**

This thesis is organized into five chapters. The first provides a historical context for understanding contemporary international medical aid by examining the work and legacy of two prominent physicians, Albert Schweitzer and Paul Farmer. This chapter also includes a brief discussion of Farmer's anthropological work and its relevance for this thesis. Farmer's prominence as not only a medical anthropologist and scholar of Haiti, but also as the single most visible proponent and executor of the type of intervention I analyzed during my fieldwork make such a discussion indispensable. This chapter not only allows for an examination of some of the continuities and shifts in international medical activites and how they have been represented and perceived in the last century, but also leads to a discussion of a common feature of many medical aid projects: the emergence of a central, heroic leader. Chapter 2 examines the work of Konbit Sante, the American-based NGO that was the HUJ's most active international partner, and whose activities and members I had privileged access to during my research. This chapter discusses some of the specificities of secular medical aid, and highlights the tensions that exist between conceptions of aid as a form of gift versus a growing effort to frame international medical interventions as a form of social justice that enacts a human right to health. Chapter 3 focuses on the hospital's medical residents, in particular their relationships with and reflections on international aid groups and agencies, as well as the dilemmas they face in considering their professional futures and their intentions to emigrate. These two chapters are fairly conventional anthropological accounts in that they describe and analyze the activities and relationships of specific groups of people. The

following two chapters deal with more abstract themes, which nevertheless represent major concerns for the individuals and organizations involved in international medical aid in Haiti. Chapter 4 explores the issue of coordination, which was a prominent concern and topic of discussion among both my Haitian and non-Haitian informants. In this chapter, I draw from research with a number of different aid groups and agencies, including several active at the HUJ and other groups in operating in rural sites. I analyze some of the motivations and incentives Haitian and international actors have for *not* coordinating, despite unanimous calls for increased coordination. The fifth and final chapter presents the framework of moral economy as a way of understanding the data presented in the preceding chapters. While the term "moral economy" has an established presence in the social sciences, it has often been left undefined by scholars who have used the term, leading to ambiguities and analytic imprecision. This section proposes a working definition of term and highlights its utility for understanding and explaining interactions such as those I observed during my research. I also analyze my findings in light of resentment and *ressentiment,* the first term referring to the emotion as it is commonly used and understood in English, and the second drawing on writings by German philosophers Friedrich Nietzsche and Max Scheler. Finally, the conclusion considers the relevance of this dissertation in light of the dramatic events that occurred in Haiti in 2010, and proposes avenues for further research in that nation and elsewhere.

## Chapter 1 From Albert Schweitzer to Paul Farmer:

## International Medical Heroes

In his 2007 book entitled *Giving: How Each of Us Can Change the World*, former U.S. President Bill Clinton wrote: "When I first heard of Paul [Farmer], I asked my daughter, who has a long-standing interest in global health issues, if she knew anything about him. She said, 'Oh Dad, he's a saint. He's our generation's Albert Schweitzer (Clinton, 2007: 37).'" Chelsea Clinton's appropriation of Dr. Paul Farmer as her generation's Albert Schweitzer is apt, not only because of specific similarities between the two physicians' lives and work, but also because of continuities in how they have been described by observers and commentators. These continuities are particularly striking given the geographic and temporal distances that separate the two men, and suggest distinct and recurring patterns in how many North Americans and Europeans conceptualize the work of what I term "international medical heroes." Juxtaposing the figures of Drs. Schweitzer and Farmer brings into relief some of the most prominent and controversial issues in contemporary medical aid, namely medical heroism, dependency, obligation, prioritization, sustainability, effectiveness, and the commodification of health care. The combined life spans of these physicians (Schweitzer lived from 1875 to 1965; Farmer was born in 1959), covers a period of enormous changes in the ways that humanitarian medicine is designed and practiced. As extremely visible and influential public figures, Schweitzer and Farmer have had no small part in shaping these changes.

In this chapter, I will compare and contrast the lives, works and legacies of these two doctors, with specific attention to their portrayals in North American media, to reactions to their work by commentators and analysts, and to the debates they provoked through their medical endeavors in impoverished settings (Schweitzer in West Africa, Farmer in Haiti and elsewhere). Both have received significant attention from both within and beyond the health sector, and both have been (and continue to be) models and inspirational figures for individuals working in the areas of international aid, development, humanitarian intervention, ethics and global health.

This analysis is relevant to this dissertation in three ways. In very concrete terms, the two doctors have had direct and indirect impacts on international health initiatives in Haiti. Although Albert Schweitzer never traveled to Haiti, his work had a decisive influence on Larimer Mellon, an American physician and philanthropist who, with his wife Gwen Mellon, established the Hôpital Albert Schweitzer, a major community health center in central Haiti which, until recently, was the most famous hospital in the country. Mellon and Schweitzer corresponded extensively over the course of nearly twenty years (Byers, 1996), and Schweitzer's legacy on the hospital today is still palpable, ranging from the institution's ever-present motto of "Reverence for Life" to the continued presence of French, German and Swiss staff and volunteers.

Paul Farmer's relevance for international health issues in Haiti is much more apparent: Farmer has spent many years working in Haiti's Central Plateau,

and the organization he co-founded, Partners in Health, along with its Haitian counterpart Zanmi Lasante, have become major figures in providing health services to Haitian citizens in a growing number of communities. Farmer's influence on the study of health and medicine in Haiti, as well as his prominence in the provision of international medical aid to the country's population warrant a discussion of his work in relation to this thesis, which I have included at the end of this chapter.

Examining the work of Schweitzer and Farmer also provides insight into a more abstract dimension of the international interventions I studied during my research. While Farmer and Schweitzer are exceptional individuals, both in terms of their personal traits and the influence they have had on others, an analysis of these physicians and their work informs our understanding of the roles and relationships of individuals I describe as "international medical heroes." These are clinicians who, through the force of their charisma, talents, and resources become influential as leaders and organizers of diverse international health interventions. In particular, many of the North American NGOs I encountered during my research are led by a charismatic individual, one who has been particularly successful in garnering resources, recruiting others, and putting medical projects into action. While Schweitzer and Farmer are among the most renown examples of international medical heroes, their cases give insight into how certain charismatic individuals working in international health influence others, shape the work of organizations and become visible as sources of inspiration (and in some cases, controversy). Considering the prominence and epic stature of these two

physicians also draws attention to the relatively low profile of other individuals and organizations involved in transnational health interventions, actors who may not be directly involved in the delivery of clinical services, or whose work treating impoverished patients may not involve renunciation or sacrifice in the eyes of outside observers.

Finally, analyzing the work of Schweitzer and Farmer sheds light on the emergence of secular humanitarianism in Europe and North America in the 20th century. Although Schweitzer and Farmer (and contemporary humanitarianism more broadly) have been profoundly influenced by Judeo-Christian traditions, their associated projects, philosophies and institutions also reflect tensions with and ambivalence toward missionary and explicitly faith-based humanitarian initiatives. As mentioned in the introduction, my study focuses primarily on the work of secular aid bodies, and an examination of Schweitzer and Farmer's work sets the stage for contextualizing and understanding the specificities of these types of interventions.

### 1.1 Albert Schweitzer

Schweitzer's biography has been traced by a number of writers who, for the most part, present a fairly consistent story. This may be due to the fact that Schweitzer wrote extensively about his own life, offering a wealth of primary-source information for subsequent retellings. Biographers, journalists and other commentators concur that aside from his intelligence, early sensitivity toward the natural world, and musical ability, Schweitzer spent a rather unremarkable

childhood in the Alsace. The son of a Lutheran pastor, he chose to pursue studies at Strasbourg, Paris and Berlin. His early intellectual pursuits were philosophical and theological, including a study of Kant and a major work on the life of Jesus. His musical talents and interests were frequently invoked by biographers – Schweitzer was a pre-eminent scholar and performer of Bach, collaborating with famed organist Charles Widor on writings about and performances of Bach's music (Brabazon, 1975; Cicovacki, 2009).

A defining moment in Schweitzer's life occurred in 1896 when, at the age of twenty-one, he chose to devote his energies to theology, music and philosophy until the age of thirty, at which point he would dedicate the rest of his life to the "direct service of humanity (Schweitzer 1953: 74-75)." Several years later, he decided to become a missionary doctor in Africa after reading a magazine article describing the needs of the Paris Mission Society. As preeminent Schweitzer biographer James Brabazon writes, medical work would be "[a]ctive, practical, merciful – everything pointed to this as Schweitzer's field of work […] (163)." After securing an affiliation with the Paris Mission Society (with the stipulation that he would not engage in any theological or liturgical activities due to his non-conformist theological views), he traveled in 1913 to the Gabon area of French Equatorial Africa. In the years that followed, Schweitzer built the famed hospital at Lambaréné. Caught in the political turmoil of both World Wars, he was taken to Europe as a prisoner of war in 1917, was released, and returned to Africa in 1924. From then until his death in 1965, he spent most of his time at the hospital, where he acted as medical director. His schedule was punctuated to by visits to

Europe and the Americas for speaking tours, fundraising, and to receive awards, most notably the 1952 Nobel Peace Prize.

As mentioned above, Schweitzer was a prolific writer, and his works span a wide range of subjects, including history, music, theology, ethics and his memoirs. Of all the ideas he put forth, however, he is best remembered for his philosophy of "Reverence for Life" (*Erfurcht vor dem Leben),* which he first conceived in 1915. Cicovacki (2009) identifies six sources that inspired Schweitzer's approach: Jesus' ethics of love; the virtue ethics of classic Greek philosophers, the Stoics' ideal of universal brotherhood; Jainist teachings that life should not be destroyed or harmed; Buddhist teachings on the essential interconnectedness of all things and Taoist philosophies on the natural world. "Reverence for Life" applies to all life, including animal and plant life, and the philosophy "does not offer specific instructions with regard to our behavior in the world, but it provides us with such a principle and encourages a healthier and more reverential attitude toward all living beings (Cicovacki, 2009: 15, 9)."

**"The Greatest Man in the World"**

Schweitzer was certainly not the first famous international humanitarian physician, but his reputation on a global scale was unprecedented. He and his work were made famous during his lifetime by newspaper and journal articles, books, and films. Well-known throughout Western Europe in the twenties and thirties (due in part to his prolific lecturing and fundraising on that continent), Schweitzer's visibility in North America increased enormously in 1947, when he

was the subject of an article in *Life* magazine entitled "The Greatest Man in the World." In addition, Schweitzer and his work were enormously popular in Japan, Korea and Turkey, where his texts were included in school curricula (Abrell, 1974: 29). His longevity (Schweitzer lived until the age of 90) also helped ensure that his work be known to a global audience during his lifetime.

The 1947 *Life* article that made Albert Schweitzer a household name in North America is extremely brief (three paragraphs), and focuses on the general details of the doctor's – his decision to travel to Africa despite a successful career in theology and music, the size of his hospital, and his critique of modern civilization and fears that he was living in a period of great decline. The historical context of his remarks had particular salience for populations still absorbing the atrocities of the Second World War and confronting the emergence of nuclear weapons. The article closes with a description of "Reverence for Life," illustrated with an anecdote that would appear repeatedly in subsequent texts about Schweitzer: his reluctance to step on a small flower in his path (Life, 1947: 96).

While the *Life* article presented Schweitzer and his work to a new audience, the tone used for writing about the doctor had already been established by previous writers. Daniel Walther's 1946 essay in the *Contemporary Review* is typical of early texts praising Schweitzer. When it was written, Schweitzer had been in Africa for over thirty years. In many texts similar to Walther's, whose intent is to describe an extraordinary man who was still unknown to much of the world, Schweitzer's work in Africa is presented as the keystone of his many accomplishments, capping an already prestigious career in theology and music.

The author, like many others, emphasizes Schweitzer's Alsatian background in order to explain some of the doctor's personal traits and characteristics, namely his taste for simplicity and his directness in interpersonal relations (Walther, 1946:161; Pichois, 1977: 121).

Although subsequent writers describe Schweitzer's life and legacy from a number of different angles, a number of recurring themes are easily identifiable in the majority of their texts. Only a small number of accounts stray from the more conventional descriptions. The tone used by most authors for describing Schweitzer and his work conveys admiration and awe, particularly in regards to two of the doctor's qualities. The first is the quantity and variety of Schweitzer's talents and strengths, whether they be intellectual or physical. Ostergaard-Christensen wrote of the hospital at Lambaréné, "[i]t is founded on one man's almost superhuman endurance and strength of will in the most difficult circumstances imaginable (Ostergaard-Christensen, 1962: 66)." As mentioned above, Scweitzer's theological writings and musical talents are frequently invoked by writers to underscore the diversity and depth of the doctor's capacities and accomplishments.

The second dimension of Schweitzer that has been repeatedly emphasized by writers is his apparent commitment to live out the values he espoused and promoted, despite the efforts and sacrifices such a commitment required. Schweitzer was aware that this dimension of his personality was visible and admired, and made it explicit it in his own writings. "My life is my argument," he claimed, and this phrase would become emblematic of how others' understood

Schweitzer's decision to pursue work as a physician in Africa. In highlighting the legacy of Schweitzer's personal qualities, Everett (1966), who described him as an "intellectual agnostic," was correct in predicting that Schweitzer's intellectual work, even after his death, would not be included among the most prestigious or canonic philosophical reflections. Rather, the Alsatian doctor was best known and is best remembered for this "unity of thought and deed," the ways in which choices about his own lifestyle and career reflected a commitment to certain principles that often required significant energy, investment and sacrifice to put into practice. "He stands as a great example of the totally involved man who could not separate thought from action, who could not separate analysis from solution, and who finally must be judged in terms of his completely or incompletely integrated life force (Everett, 1966: 530)."

Perhaps because Schweitzer came to represent a moral and ethical standard rather than a specific philosophical or political program, a wide range of authors sought to apply his approach and teachings to their particular activities or areas of expertise. Medicine is an obvious domain where Schweitzer's name and legacy figure prominently. At times he is mentioned simply to invoke altruism in medicine, as in the text as in an article entitled: "Albert Schweitzer or Ivan Boesky? Why We Should Reject the Dichotomy Between Business and Medicine." (The article, incidentally, makes no subsequent mention of Albert Schweitzer, but rather discusses, "the moral identity of health care workers [Wicks, 1995: 339].") Beyond medicine and its affiliated fields, Schweitzer is

invoked by scholars in education, philosophy, psychology, political science, and a wide range of other fields (Abrell, 1974).

Schweitzer was not without his detractors. For the most part, commentators tempered their effusive praise for the physician with specific critical remarks and observations. Some of the critiques that appear the most frequently concern Schweitzer's refusal or reluctance to adopt "modern" technologies at the hospital, his authoritarian and autocratic nature and tendencies, his paternalistic and colonial relationships with African patients and employees, his failure to train African medical staff, and his neglect of his wife and daughter due to his medical work (Ballard, 1965: 228; Brabazon, 1976: 352-353). For the most part, these writers wrote with nuance about Schweitzer's less laudable traits and opinions, tempering their critiques with justifications that drew on Schweitzer's more positive traits. Manuel Davenport, writing about what he called Schweitzer's "moral paternalism" said:

> "…the more clearly he saw the intrinsic good of things African and the current evil of things European, the more he believed that the Africans still needed whites with moral authority to guide and protect them—but now to possess moral authority, the whites, in additional to being ethical in motivation and skilled in techniques, must be able to appreciate and develop the positive qualities of the Africans (Davenport, 1974: 121)."

Oftentimes, Schweitzer's failings and shortcomings were used by authors as evidence of the doctor's "humanity" – the weaknesses that attested to his identity as an imperfect human like any other made his positive characteristics all the more extraordinary.

A much smaller group of authors portray Schweitzer and his work in a completely negative light. This was predicted by Norman Cousins, who in 1960 wrote, "Albert Schweitzer will not be immune from attack. There may be a

period of carping and intended exposure, much of it with an air of fresh discovery and all of it in a mood of disillusion (Cousins, 1960: 145)." In this vein, British writer Gerald McKnight seems to take pleasure in condemning not only the weaknesses and failings listed above, but all of Schweitzer's behaviors and personality traits, down to his behavior at meals and musical abilities. McKnight is particularly contemptuous of Schweitzer's admirers, calling them "… the little legendeers, the sycophants' chorus line, the adulators and image-makers (McKnight, 1964: 11)." He is critical of most written accounts of Schweitzer and Lambaréné, saying, "[t]he greater number of writers seem to have fallen under a spell, or persuasion, during their sojourn in the colony. They have left works which bear little evidence of truth and objectivity. These confections have seriously distorted the legend of Albert Schweitzer." He adds, "If future scholars are to embark on a quest of the historical Schweitzer, […] they will need an unusually sweet tooth to escape nausea (170)." McKnight's book, however, did not have a significant impact on Schweitzer's legacy. It is possible that the writer's extensive personal attacks on Schweitzer's behavior and character undermined his arguments, which would have found sympathizers had they been presented in a less vindictive tone. One reviewer described McKnight's writing as a "constant drip of feeble spite," and suggests that the book's author was motivated in part by envy: "[H]e pursues the Man with a dull, pertinacious hostility, an obsessive anxiety to find discreditable interpretations of the most innocuous biographical data, which can only make one reflect how much greatness must still smoulder, even in the wreck of Schweitzer, to arouse so much

envious malice (O'Brien, 1964)." I will return to the issues of disillusionment and exposé later in this text.

All of the commentators mentioned above are Europeans and North American. There are few texts by African scholars that discuss Schweitzer and his legacy, which makes analyses such as Sylvère Mbondobari's essay on the depiction of Albert Schweitzer in cinema particularly noteworthy. He focuses in particular on *Le Grand Blanc de Lambaréné by* Camerounian director, Bassek Ba Kobhio. The film intended to "unveil the true nature of this man who is adulated in the West, to tell of his racism, his colonialism, his disdain for his *indigènes*... (Mbondobari, 97)." For Mbondobari, the film's success lies not in presenting Schweitzer "as he really was" (and the author emphasizes the film's fictional dimensions) but in presenting an African perspective on a man whose legacy in Africa has been primarily created by non-Africans, and the resulting tensions between "the desire to break away from an image and the complexity of a mythical personality (104)." Additional African perspectives on Schweitzer and his legacy would contribute both to a body of empirical research on the doctor, his activities, and their immediate impacts, but also to analyses of how various groups and populations interpret and make meaning of medical missions and transnational health interventions.

As anthropologist Peter Redfield recently wrote in an article on the emergence of secular humanitarianism, Schweitzer "came to exemplify the medical mission as a moral calling (Redfield, nd: 16)." Redfield highlights that while Schweitzer's medical activities in Africa did not focus on religious

conversion and evangelization, they should not be considered completely secular. Medical care was "the means to realize the humanistic promise of Christianity, and in doing so offer a measure of redemption for the failures and sins of civilized rule (Redfield nd: 17)." Redfield also describes the modifications that subsequent international medical aid initiatives, specifically Médecins sans frontières (MSF), made to Schweitzer's model, specifically in the areas of scope and mobility, the compensation of traveling health professionals, and working with a mandate and approach that did not require the elaboration of a philosophy of life.

### 1.2 Paul Farmer

While Farmer has not written extensively about his own life, biographical elements often appear in the interviews he accords, and Tracy Kidder's recent biography, *Mountains Beyond Mountains: The Quest of Dr. Paul Farmer, A Man Who Would Cure the World,* provides a thorough coverage of Farmer's background and biography.[6] Born in 1959 to working-class parents in Massachusetts, Farmer grew up in Alabama and Florida, where his family resided for long periods in a school bus and on a boat. Kidder's recounting depicts a childhood of success in school, early exposure to literature and few material comforts. Farmer first traveled to Haiti in 1983, having met Haitian migrant workers through progressive Catholic communities while an undergraduate at Duke University. He continued to travel to Haiti during his years of graduate study at Harvard, where he earned both a medical degree and a doctorate in anthropology. The late 1980s were a particularly tumultuous period in Haiti, with

[6] The book followed a prominent article in The New Yorker magazine in 2000.

the fall of the Duvalier dictatorship and a string of provisional governments and military coups in the years that followed. Along with Episcopal Church leaders and other international students and volunteers, Farmer established a clinic in the rural settlement of Cange, and eventually co-founded the American and Haitian sister organizations (Partners in Health and Zanmi Lasante) that would come to structure and support the clinic and other health initiatives. In the years that followed, PIH developed similar programs by founding organizations in Peru, Russia, and several other countries. Farmer has spent less time in Haiti in recent years, having relocated with his family to Rwanda (his wife, Didi Bertrand Farmer is a native of Cange), where he works with PIH and its Rwandan counterpart, Inshuti Mu Buzima (IMB) to expand healthcare (particularly HIV treatment) and social services for rural Rwandans.

Farmer's earliest research described the ailments of *move san* (bad blood) and *lèt gate* (spoiled milk) among rural Haitian women, using the framework of explanatory models to show the contrast between the afflicted women's and local healers' understanding of the conditions as being rooted in malignant emotions and those of biomedical doctors who dismissed the ailments. He concluded that existing models of folk illness, somatization, or Western psychiatric categories are inadequate for understanding conditions such as *move san* and *lèt gate,* which instead highlight the need for an "anthropology of suffering" (Farmer, 1988). In later works, Farmer has drawn from several theoretical models, including Galtung's concept of structural violence in order to illustrate the pernicious effects of poverty and inequalities on populations, as well as world systems

theories developed by scholars such as Wallerstein and Mintz 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. His 1992 monograph *AIDS and Accusation: Haiti and the Geography of Blame*, examines the arrival of HIV/AIDS in Haiti's Central Plateau, local responses to the virus, and the ways in which Americans' association of the diseases with Haiti was the continuation of centuries of prejudice and stigma against the country and its people. Farmer also draws from liberation theology, specifically from the endeavor to understand the forces of oppression in order to overthrow them.

Throughout his writings, Farmer describes the illnesses of individuals he has encountered or treated in Haiti. 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 case 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 (Farmer, 1992; 2003).

In his more recent writings, Haiti most often appears to illustrate Farmer's claims and arguments related to the provision of health services. 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 writings and a motivating force in his clinical activities.

**"From Harvard to Haiti"**

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." He has been enormously influential within anthropology and medicine, and both his clinical practice and numerous publications have attracted attention worldwide. Farmer's recognition by colleagues are particularly noteworthy: he has been awarded several major prizes by anthropological and medical societies, has received honorary doctorates from several major US universities, and is frequently invited to deliver speeches and addresses at conferences and other international events. He was recently named UN Special Deputy Envoy to Haiti by Bill Clinton.

For Farmer, the impact of Kidder's biography was analogous to that of the 1947 *Life* article about Schweitzer. While Farmer had been well known among anthropologists, Haitianists and international health scholars and activists, Kidder's volume extended Farmer's renown to a larger audience. The book

became a best-seller, was named a Notable Book by the New York Times, and is taught in many schools and universities (particularly in medical schools, where it is regularly assigned as required reading for first-year students). *Mountains Beyond Mountains* focuses primarily on Farmer as an extraordinary individual: his brilliant intellect and photographic memory, his choice to reject material comforts and pursue a lifestyle of extraordinary self-sacrifice, and his unwavering commitment to provide health services to poor people in Haiti and other countries.

Kidder describes Farmer's work in a variety of settings ranging from shacks in Peru to meetings with officials from the World Bank in Russia. Much of the book takes place in Haiti, which Farmer has called his "greatest teacher." It is in Haiti that Kidder sees many of Farmer's extraordinary traits in action – his thorough and intimate knowledge of Haitian society and history, his ability to rally resources and create a functioning health-care system in an extremely impoverished and isolated area, and the tenacity of his convictions, exemplified in the following statement: "The problem is, if I don't work this hard, someone will die who doesn't have to. That sounds megalomaniacal. I wouldn't have said that to you before I'd taken you to Haiti and you had seen that it was manifestly true (Kidder, 191)."

Farmer's work illustrates the increasing overlap and intensified relationship between humanitarianism and human rights. Both rhetorics[7] are

[7] I use rhetoric in this context to refer to persuasive language and arguments, not to imply that human rights or Farmer's use of them are void of meaning.

prominent in Farmer's work, which uses the language and logic of human rights 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, as he frequently draws on his status as a physician to reinforce his claims and justify his perspectives. Doing so contributes to his goal of convincing readers of the feasibility and desirability of treating poor patients. Partners in Health's success has not gone unnoticed – the group's language, strategies and model have become an inspiration for international health projects who recognize its efficacy both in treating patients and garnering support. In the Haitian context, PIH and its partner organization Zanmi Lasante are one of the country's most prominent and successful international medical groups, and they are expanding beyond their original base in the Central Plateau to operate health establishments elsewhere in the country, some of which were abandoned or reclaimed from other foreign NGOs. The organizations have recently broken ground on a teaching hospital in the city of Mirebalais that will be the country's second largest. PIH and ZL have also gained increased prominence in the aftermath of the 2010 earthquake and cholera epidemic. While the organizations' activities in Haiti are run by a large local and smaller expatriate staff, it remains to be seen if Farmer will increase involvement in a site to which he is so clearly and deeply attached.

### 1.3 Schweitzer and Farmer

Although Chelsea Clinton is not the only person to have drawn a parallel between Albert Schweitzer and Paul Farmer, there are clues that signal discontinuities between the two men. A biography of Farmer recounts his visit to the Hôpital Albert Schweitzer (HAS) on his first trip to Haiti: "He had high expectations, and it was a good-looking hospital, he thought. But it was staffed mainly by white, expatriate doctors. He'd imagined something different—a hospital at least partly devoted to training Haitians. Besides, the Schweitzer didn't have a job for him just then, in spite of his Mellon contact. He went back to the city, feeling, he'd say, 'deflated' (Kidder, 2004: 65)." HAS should not be considered a Haitian extension of Albert Schweitzer's African work – Schweitzer was not officially affiliated with the hospital (which was founded by Americans Larimer and Gwen Mellon), and never even traveled to Haiti. This vignette is indicative, however, of Farmer's dissatisfaction with the forms of international medical aid he found in Haiti, aid that was profoundly influenced by Schweitzer's work and legacy. It also hints at some of the measures he would take to correct what he perceived as failings in other establishments. I will now turn to differences and similarities in the work of the two men, as well as in their portrayals and representations by observers. The divergences attest to some of the significant changes that have taken place in medical aid in the last century. The continuities, particularly in representations of the two men and their work, suggest the existence of an iconic figure in the North American imaginary: the international medical hero, a figure that I will describe in detail below.

**Divergences**

Schweitzer and Farmer are most often portrayed as solitary individuals whose drive is fueled by their own convictions and motivation rather than as members of particular groups or societies. For Schweitzer, this has been more appropriate: while he certainly depended on his hospital's staff and the generosity of international donors, his hospital was very much his own operation in terms of its governance, functioning and priorities. A Danish physician, who spent several months working with Schweitzer, wrote in 1962, "The hospital at Lambaréné is purely one man's work in a country which knows neither civilization nor welfare (Ostergaard-Christensen, 1962: 35)."

Farmer, on the other hand, co-founded the group Zanmi Lasante (ZL) as a health project and clinic in Cange in the early 1980s with a Haitian Episcopal pastor and his wife, and with Ophelia Dahl, a British volunteer. Partners in Health (PIH) was founded in Boston in 1987 by Farmer, his former college roommate, and a wealthy benefactor. While Farmer has always been the most visible figure in PIH/ZL, he has worked with professional colleagues and the organizational structure of NGOs in ways that Schweitzer never did. At the Zanmi Lasante Sociomedical Complex in Cange, the site of PIH/ZL's original projects, the hospital has a Haitian medical director and nearly all Haitian staff. Although PIH/ZL does employ a limited number of foreign medical staff in Haiti and will occasionally host foreign clinicians as volunteers, they represent a much smaller percentage of the total staff than the European and American doctors and nurses did at Lambaréné.

Another important distinction between Farmer and Schweitzer involves their immersion in and understanding of the societies where they work(ed). This critique was frequently leveled at Schweitzer, who never learned to speak an African language and restricted his activities and interactions to the hospital, where he maintained ultimate authority and many aspects of a European lifestyle. Farmer, on the other hand, not only became fluent in Haitian Creole and French over the course of his studies, but also became intimately familiar with the social, economic and political dimensions of life in rural Haiti, writing texts on popular medical classifications and their moral significance, histories of Haiti in local, national and international perspective, and descriptions of the lives and living conditions of impoverished Haitians in their own terms. Farmer's extensive knowledge of the daily lives and experiences of rural Haitians has often been used to explain the successes of Partners in Health.

In a parallel vein, Schweitzer and Farmer have had remarkably different relationships with the respective governments in their areas of intervention. Schweitzer's contacts with the government of French Equatorial Africa (1910 – 1958) appear to have been minimal, and neither he nor his biographers mention his relationship with colonial authorities other than in the context of his removal to Europe as a prisoner of war during the First World War. The hospital at Lambaréné operated as a relatively autonomous entity, and in Schweitzer's time, does not seem to have been subjected to governmental inspections or reviews.

Farmer's relationship with the Haitian state has been quite different. Farmer arrived in Haiti during the final years of the Duvalier dictatorship, and

was in the country for much of the turbulent period between the departure of Jean-Claude Duvalier in 1986 and the election of Jean-Bertrand Aristide in 1990. Farmer was a vocal supporter of Aristide, his Lavalas political movement and the liberation theology that inspired the former priest. He wrote passionately in Aristide's defense during the violent coup (1991 – 1994) that put the latter into exile. For many years, however, PIH/ZL operated fairly autonomously from the Haitian government, a practice about which Farmer would later express regret. In addition to PIH/ZL's increased collaborations with the Haitian Ministry of Public Health and Population (MSPP) in recent years (through jointly operated hospitals and health centers, for example), Farmer has worked increasingly with governmental bodies and agencies and, as mentioned earlier, is currently the UN Special Deputy Envoy to Haiti.

Finally, the two physicians express markedly different opinions on the issue of self-rule and autonomy in the populations where they work. Schweitzer is explicit in his arguments against African self-rule, which are worth quoting at length:

> "That of those who were commissioned to carry out in our name the seizure of our colonial territories many were guilty of injustice, violence, and cruelty as bad as those of the native chiefs, and so brought on our heads a load of guilt, is only too true. Nor of the sins committed against the natives today must anything be suppressed or whitewashed. But the willingness to give these primitives and semiprimitives of our colonies an independence which would inevitably end in enslavement to their fellows, is no way of making up for our failure to treat them properly. Our only possible course is to exercise for the benefit of the natives the power we actually possess, and thus provide a moral justification for it. Even the hitherto prevailing "imperialism" can plead that it has some qualities of ethical value. It has put an end to the slave trade; it has stopped the perpetual wars which the primitive peoples used to wage with one another, and has thus given a lasting peace to large portions of the world; it endeavors in many ways to produce in the colonies conditions which shall render more difficult the exploitation of the population by world trade. I dare not picture what the lot of

> the native lumbermen in the forests of the Ogowé district would be if the government authorities which at the present time preserve their rights for them in opposition to the merchants, both white and black, should be withdrawn.
>
> What so-called self-government means for primitive and semiprimitive peoples can be gathered from the fact that in the Black Republic of Liberia, domestic slavery and what is far worse, the compulsory shipment of laborers to other countries, have continued down to our own day. They were both abolished on October 1st, 1930--on paper (Schweitzer, 1953, 147-148)."

He goes on to explain that while the ideal situation for "primitive people," would be a total isolation that would permit them to develop through the various stages of agriculture and artisanry to reach a state of "true civilization." This is impossible, he argues, because of desire of these populations to earn money by participating in international trade, that unchecked, leads to exploitation and oppression. Colonial governments working in the interest of the populations by limiting and structuring trade are, in Schweitzer's opinion, the best alternatives.

Farmer, on the other hand, is explicit in his calls for Haitians' right to self-rule and democratic government, particularly in writings in the 1990s opposing the 1991-1994 military coup in Haiti and various US interventions, both military and economic, that have worked against the interest of Haiti's impoverished majority. In recent years, however, Farmer has written less explicitly about American foreign policy in Haiti, focusing instead on the areas of international human rights and social justice more broadly. His last text explicitly addressing Haitian politics appeared in 2004, an article entitled "Who Removed Aristide?" and situated the Jean-Bertrand Aristide's 2004 removal in the context of Haiti's turbulent history as an object of international interventions (Farmer, 2004). It may be that PIH/ZL's prominence in the health sector and other spheres in Haiti, as well as Farmer's own visibility and influence have limited his ability to take

strong public positions vis-à-vis many issues involving the Haitian government and Haitian-American relations.

**Similarities**

Despite the many differences in their strategies and philosophies, it is possible to find shared opinions that Schweitzer and Farmer have held, or at least similar perspectives whose expression may have differed due to socio-historical context and respective intellectual and philosophical influences. Both had the opinion that specific technologies or resources should not be reserved for a particular segment of the world's population. Schweitzer was frequently criticized for his refusal to "modernize" the hospital at Lambaréné, but his stated opinion on the matter is quite clear: "It is unthinkable that we civilized peoples should keep for ourselves alone the wealth of means for fighting sickness, pain and death which science has given us. If there is any ethical thinking at all among us, how can we refuse to let these new discoveries benefit those who, in distant lands, are subject to even greater physical distress than we are (1953: 151)." Farmer's argument on this matter is Similarly based on ethics, but also encompasses a more analytical critique of common international development strategies. He recounts an early exchange with a Haitian priest regarding well-built latrines in Cange:

> "Unwisely, I asked whether the latrines were really "appropriate technology" for such a poor village. The priest was furious. "Do you know what 'appropriate technology' means?' he finally answered. "It means good things for rich people and shit for the poor." With the help of my (sometimes stern) Haitian hosts, I've since come to believe that the hypocrisies of development are not only morally flimsy but also analytically shallow. Many of the positions advanced in the development field are underpinned by a zero-sum approach: only exceedingly limited funds are available for "sustainable" project, the logic goes, and those

> who work for the poor must choose between, say, high-tech interventions and preventive services. Such Luddite critiques of technological advancement treat poor villages like Do Kay as if they were cut off from the rest of the world (Farmer, 2001: 21-22)."

It is safe to assume that Farmer would be critical of the many international projects throughout rural Haiti that introduce technologies and equipment that are completely maladapted for the environment they are destined to and end up representing additional burdens and expenses for the intended beneficiaries. (The hydroelectric dam at Péligre that displaced the population of Cange is a prime example, one that Farmer frequently denounces in his writing and speeches.) But he uses a critique of "appropriate technology" primarily to further his arguments for HIV medications in rural Haiti, arguing against claims that such medicines are too expensive or complicated to dispense in such impoverished settings.

Another argument that both Schweitzer and Farmer put forth is that wealthy and colonial powers have a debt towards the populations in the territories they have conquered and exploited, and providing health care is a means of paying that debt. In "Out of My Life and Thought," Schweitzer wrote, "…whatever benefit we confer upon the peoples of our colonies is not beneficence but atonement for the terrible sufferings which we white people have been bringing upon them ever since the day on which the first of our ships found its way to their shores (Schweitzer, 1953: 152)." Schweitzer's rationale for white intervention in Africa rests both on an acknowledgement of the impact of colonialism and international trade on African societies as well athe categorization of populations that he understands to be at an earlier stage of development:

> Have we white people the right to impose our rule on primitive and semiprimitive peoples--my experience has been gathered among such only? No, if we only want to rule over them and draw material advantage from their country. Yes, if we seriously desire to educate them and help them to attain to a condition of well-being. If there were any sort of possibility that these peoples could live really by and for themselves, we could leave them to themselves. But as things are, the world trade which has reached them is a fact against which both we and they are powerless. They have already through it lost their freedom. Their economic and social relations are shaken by it. An inevitable development brought it about that the chiefs, with the weapons and money which commerce placed at their disposal, reduced the mass of the natives to servitude and turned them. It sometimes happened too that, as in the days of the slave trade, the people themselves became merchandise, and were exchanged for money, lead, gunpowder, tobacco, and brandy. In view of the state of things produced by world trade there can be no question with these peoples of real independence, but only whether it is better for them to be delivered over to the mercies, tender or otherwise, of rapacious native tyrants or to be governed by officials of European states (Schweitzer, 1953: 152)."

Farmer's approach to framing contemporary health interventions as a way of righting past wrongs is both more detailed and less explicit than Schweitzer's. As mentioned above, Farmer's analyses have been shaped work in political economy and world systems theories. In his early writings on Haiti, Farmer described the international interventions in that country that contributed to its population's poverty and suffering. His book *The Uses of Haiti* focuses in great detail on French colonialism and U.S. neo-colonialism, themes that also appear prominently in *AIDS and Accusation* (Farmer, 1994; 1992). His description of specific economic policies, military interventions, and historical events are much more detailed than any text Schweitzer wrote about West Africa, and would provide significant support for arguing that U.S. and French citizens have an obligation to redress the faults of their ancestors and their nation-states. Instead however, he draws on human rights and social justice to build arguments that, while articulating compelling claims for entitlements and equity for impoverished and marginalized populations, are less explicit about the specific obligations of

those who are *not* impoverished or marginalized. He hints at what these obligations might entail: "By arguing that we must standards high, we must also argue for the redistribution of some of the world's vast wealth." He continues: "[t]o argue that human rights abuses occurring in Haiti, Guatemala, or Rwanda are unrelated to our surfeit in the rich world requires that we erase history and turn a blind eye to the pathologies of power that transcend all borders (Farmer, 2003: 245)." His specific recommendations, however, tend to center on the experiences of PIH/ZL and describing the successes they have had in making medications available to rural Haitians and other impoverished populations without emphasizing precise obligations based on inherited relations of inequality and exploitation.

**International Medical Heroes**

While Schweitzer and Farmer as physicians, scholars and humanitarians may be as different as they are similar, as public figures, the parallels between how they have been described and represented by others are particularly striking. These parallels suggest the existence of enduring and pervasive themes and styles that characterize how certain types of health care workers, (which I have termed international medical heroes) are represented to and viewed by North American audiences. Other high-profile examples of this figure include physicians Thomas Dooley (an American who worked in Laos in the 1950s), and Norman Bethune (a Canadian who worked in Spain and China in the 1930s and 1940s). Most often, these individuals are male physicians, but women and nurses are occasionally

represented in a similar light. Portrayals of these international medical heroes circulate in media and shape popular understandings of international medicine, clinicians' work and roles in larger context, and the relationships between nations and populations that involve obligations and assistance. While physicians in Western societies have held a variety of tangible and symbolic roles (including healer, entrepreneur, moral authority, regulator, and others), specific attributes of the international medical hero include selflessness, altruism, courage, tirelessness, resourcefulness and compassion. In addition, these heroes have the effect of inspiring others to carry out similar endeavors and initiatives, either through the concrete recruitment of supporters, volunteers and collaborators, or indirectly through texts and speeches, influential portrayals by others, and reputation more broadly. In reading about these individuals, several recurring motifs become apparent. The examples selected below are specifically related to Drs. Schweitzer and Farmer, but are present in depictions of other international medical heroes.

The first of these is the idea that the international medical hero fulfills specific needs beyond those of the population he or she is directly serving as a clinician. Commentators describe a need to have such figures to emulate or even simply to admire. Norman Cousins wrote,

> "If Albert Schweitzer is a myth, the myth is more important than the reality. For mankind needs such an image in order to exist. People need to believe that man will sacrifice for man, that he is willing to walk the wide earth in the service of man. Albert Schweitzer is a spiritual immortal. We can be glad that this is so. Each age has need of its saints. A saint becomes a saint when he is claimed by many men as their own, when he awakens in them a desire to know the best that is in them, and the desire to soar morally… […] At Lambaréné I learned that a man does not have to be an angel to be a saint (Cousins, 1960:220)."

Echoing this sentiment, Ballard wrote: "Europeans have needed the reassurance of the old man at Lambaréné." His image "left us with a feeling of pleasure that

he was there, in some way representing the things which we would have been doing if other responsibilities had not forbidden (1965: 225)." Similarly, in a website featuring the work of Paul Farmer, one reads, "Society needs heroes to rejuvenate, re-energize and renew itself with visions of the possible. That's what heroes do (www.myhero.com)." In this way, the heroes' patients are not the only ones to benefit from his or her work; anyone who comes into contact with the heroes (directly or indirectly) and is inspired to emulate them benefits from an opportunity for self-improvement.

A second motif is that of renunciation and self-sacrifice, which appear commonly in writings about both Schweitzer and Farmer. Before beginning their work abroad, both lived in relatively privileged conditions, and benefitted from affiliations with powerful institutions. Commentators assume and explicitly state that they could have stayed in their native environments and enjoyed the material comforts available to them. Authors highlight that both had accomplished a great deal at an unusually young age, and therefore could have enjoyed rewarding careers and a high standard of living in their respective places of origin. Writers who visited Lambaréné and Cange often described in detail the simple and rudimentary living situations that these doctors chose over upper-class dwellings in Europe and the United States (Schweitzer's piano was often mentioned as a quaint anomaly in his otherwise Spartan residence). About Farmer, Kidder writes: "Obviously, a young man with his advantages could have been doing good works as a doctor while commuting between Boston and a pleasant suburb — not between a room in what I imagined must be a grubby church rectory and the

wasteland of central Haiti. The way he talked, it seemed he actually enjoyed living among Haitian peasant farmers (Kidder, 2004: 7)." The decision to pursue medical projects in impoverished settings when doing so is neither financially lucrative nor physically comfortable is described by authors and observers as one that for these men was not inevitable, but reflected a conscious choice. Writers hardly ever suggest that the decision might have been explicitly made in order to achieve a particular hero status. Desire and ambition for recognition and adulation could be interpreted as serious personal defects that would undermine one's position as a hero, and are among those things which must be renounced to attain hero status. A paradox ensues where the hero becomes successful and influential ostensibly by rejecting more conventional means of becoming successful and influential.

A third theme prominent in depictions of international medical heroes is a confrontation with danger in some form. In the cases of both Schweitzer and Farmer, French Equatorial Africa and Haiti represent for many observers a confrontation with poverty, an unfamiliar and uncomfortable climate, a lack of material comforts, the risks of political and social instability, and contact with African and Afro-Caribbean populations infamous for their alleged "savagery," lack of civilization, and use of malicious magic. The confrontation with danger is heightened in descriptions of both Schweitzer and Farmer by accentuating certain conditions and personal characteristics: their youth, their lack of prior experience in such impoverished settings, and their relative isolation from other foreigners during their early encounters. With patience, intrepitude and charisma, the

international medical hero is able to resolve difficult situations, build relationships with locals for collaboration, and eventually gain a certain amount of influence in a harsh and potentially hostile environment.

Although Schweitzer and Farmer are two of the most prominent examples of international medical heroes, the archetype is also applicable to individuals working on a much smaller scale and with much less visibility. The majority of North American NGOs I encountered in Haiti are led by a charismatic individual, one who has been particularly successful in garnering resources, recruiting others, and putting projects into action. As in other contexts, these individuals often tend to be male physicians, whose work is usually supported by medical and non-medical group members whose professional status, age, and experience in Haiti were frequently less than that of the hero.[8] International medical heroes were not a prominent feature in all of the groups and agencies I studied; interventions by governmental and large multi-national agencies were more often implemented by individuals in subordinate and heavily bureaucratized positions than by charismatic leaders. In smaller, non-governmental groups, however, members of the organizations were nearly always able to identify a "driving force" for their group – an individual whose energy and initiatives were essential to the functioning of the organization and to the implementation of interventions.

[8] I did meet several women international medical heroes in Haiti, and it seems likely that this figure will become less gendered with time. Nearly all, however, were physicians. While North American NGOs working on issues related to education, food, orphans, and evangelization were often spearheaded by non-professionals, the degree of hierarchy and specialization in medicine made it difficult for someone other than a high-status clinician to assume a leadership role in medical interventions.

The centrality of a single individual in the functioning and success of international medical aid organizations was described both positively and negatively by the group members I interviewed. For the most part, the heroes' roles and relationships with other members resulted from individuals' personal traits and characteristics – NGOs' fairly flexible structures and governance allowed individuals to negotiate a position in the group that corresponded to their interests, availabilities, and personalities. Many individuals told me that they preferred to take what they called "supporting roles," and let someone else lead and make decisions. Generally, the heroes were appreciated by their groups' members, who looked up to them and were grateful for their work and leadership, although some members expressed concern about their group's future in the case of the hero's inability to carry out his or her functions.

Although most of the groups I observed maintained relatively harmonious organizational relationships, some evidence of conflicts related to centralized leadership emerged. Prior to my research, two major actors in a small medical NGO had had a major conflict over the group's leadership and priorities, with one nurse who ultimately left the organization accusing the other leader of "killing her baby" (in other words, making significant changes to the group's structure and functioning). Conflicts among international members of aid groups most frequently revolved around prioritization of activities, management of resources, and differences in personality and perspectives. It is not uncommon to find organizations in Haiti that began as offshoots or splinter movements of previously existing groups, either in the context of intense conflicts or more subtle

divergences in projects and priorities.

Thus far, the description and analysis I have provided of international medical heroes implies that they are not native to the sites where they intervene, but travel there from other (usually wealthier) countries. There are cases in which Haitians take on or be attributed the role of medical heroes, and in the case of emigrants, a transnational dimension of their aid is also be present. In the organizations included in my study, Haitians and members of the Haitian diaspora occasionally acted as a group's central, charismatic and heroic figure, but more often occupied a less prominent, subordinate role that nonetheless comprised some heroic dimensions. This included the Haitian-American physician who spearheaded a university-based initiative to provide HIV+ positive patients with medical services, including anti-retroviral medications; the community health agent who emerged as a local authority figure and spokeswoman, looking after neighborhood children and organizing her area's residents to pressure municipal authorities into channeling resources toward their neighborhood's minimal infrastructure; the Haitian medical resident whose charismatic personality, intelligence and dedication made her an obvious choice for an American organization seeking out a local partner for research and intervention; and the Cuban-trained Haitian physician who was appointed medical director of a rural hospital that operates out of a partnership between a US-based NGO and the Haitian Ministry of Health. I will now turn to some of the conditions that permitted these individuals to emerge as heroic figures, and examine some of the constraints that often keep Haitian medical heroes from attaining the visibility and

influence of international medical heroes.

Some of the characteristics of international medical heroes also apply to Haitian clinicians who are deemed heroic figures, but with some important differences. The aspect of renunciation is particularly complicated in Haiti, where only a small segment of the population would be able to renounce material gain and access to opportunities or resources commensurate with the renunciation of international heroes. Most Haitians do not have lucrative jobs or a secure, comfortable lifestyle to renounce in the first place. Even Haitian professionals, whose living conditions and future prospects are inarguably better than most of their compatriots, struggle with debt, insecurity, and the pressures and demands related to supporting their families and kin networks. In a context where obligations and loyalty towards *moun pa* (one's people) are a defining feature of one's identity and life choices, and where failure to maintain networks through the redistribution of capital, resources and services can have devastating consequences, it particularly difficult for Haitian health workers to renounce professional ambition and personal advancement. Even more striking is the contrast between international medical aid workers' and Haitian health professionals' prospects in terms of national destinies. Turmoil in Haiti for a foreign clinician can be mitigated by a return to one's home country and a shift toward prior or alternate occupations. Haitian clinicians, however, particularly those lacking the status and documentation needed to travel or work abroad, are much more vulnerable to the negative outcomes of instability and what many describe as Haiti's dismal future. Even having renounced professional or personal

objectives, the international medical hero can feasibly choose to return to a high quality of life in his or her country of origin; this scenarios is not as possible for clinicians from Haiti or other impoverished settings.

Nevertheless, Haitian clinicians do, of course, make a wide range of renunciations, and some of these are noticed and appreciated by outside observers. In the case of health workers who have emigrated and return to Haiti either permanently or periodically to be involved in aid, commentators often remark that the person in question was not obligated to return to Haiti, and that many members of the diaspora or minimally or not at all involved in efforts to improve their home country. Another group includes health workers who had the possibility of emigrating but chose not to, or those who make professional choices to serve needy segments of Haiti's population instead of or in addition to providing better remunerated care to wealthier patients. These individuals are nearly always described by observers as "dedicated" and/or "devoted," terms that have religious connotation in the Judeo-Christian tradition of apartness and commitment to sacred purpose. I return to these issues in Chapter 3, which draws on interviews with Haitian clinicians concerning international aid and their own projects for emigration.

While renunciation is a component of medical heroism that is often applied by observers to the experiences of Haitian clinicians (albeit it in modified form), the component of a confrontation with danger is rarely mentioned in representations of the latter's work, particularly in comparison with depictions of foreign aid workers. This may stem from the fact that for most foreigners, travel

to Haiti in and of itself is considered the most dangerous aspect of their work. This loses its relevance when discussing Haitian and diaspora health workers, who are already in the country or familiar with it from living there previously. The "danger" foreigners experience in Haiti is also expressed in terms of class and race – an immersion among poor Blacks, an immersion that many international aid workers assume is a non-issue for Haitian health workers. In talking with Haitian clinicians, however, I found that many of them found experiences such as working in rural areas or parts of the country they were unfamiliar with to be extremely disconcerting, especially at first. While most eventually adapted to being outside and urban area and separated from their families, nearly all found these experiences trying on a number of different levels, and some abandoned them altogether. In addition, health and other professionals felt extremely vulnerable and targeted by the waves of kidnappings that began in 2005 and continue to target not only wealthier Haitians, but middle-class and poorer individuals as well. Most foreigners I met in Haiti were not aware of the fear these kidnappings had provoked among Haitian health professionals. Overall, they considered their own travel to and activities in Haiti to be a dramatic confrontation with various forms of danger, whereas Haitian professionals' presence in the country was described as more matter-of-fact and mundane.

The group I studied the most closely during my research, Konbit Sante, was an exceptional case in that its activities and functioning are not as centered around the charismatic personality of a single individual as in the case of most other medical aid NGOs. While this seems to have been the case in the past, both

the particularities of individual personalities in the group and its organizational model and operating strategies are not conducive to the prominence of a single heroic figure. As I discuss in the following chapter, this appears to have contributed to the group's success in attaining its stated goals.

### 1.4 A Note on Paul Farmer

Because of Paul Farmer's prominence as both a medical anthropologist who has written extensively on health and society in Haiti and a physician involved in the kind of international medical aid to Haiti that I examined during my research, it seems essential that I position my study in relation to Farmer's writings, and situate my fieldwork and research activities vis-à-vis PIH/ZL's approach, programs and activities.

I first encountered Farmer's writings as an undergraduate, shortly after my first trip to Haiti. I was impressed by the scope and breadth of his analyses, his ability to link the lived experiences of rural Haitians with macro-level forces and phenomena, and his masterful use of a wide range of primary and secondary sources. I have also been inspired by his deep affection for the people of Haiti and his tireless efforts to improve their living conditions, efforts which have produced tremendous results. I continue to recommend Farmer's writings to people wishing to learn more about Haiti, particularly *AIDS and Accusation*, which I have assigned to my undergraduate students in university anthropology courses. I also direct people wishing to donate funds to health efforts in Haiti to

Partners in Health, as I feel the group's work represents some of the best and most successful international health interventions in the country.

Farmer's academic writings were a major influence in shaping the focus and content of my doctoral research. Not only did they inform my understanding of Haitian history, society, and international relations, but I also used his work to help identify key areas that have not been the subject of extensive anthropological research. Foremost among these is the presence and activities of hundreds of international groups and agencies providing health care throughout Haiti. Farmer's texts rarely mention the existence of organizations other than PIH/ZL. He also makes scant mention of MSPP and its national system of dispensaries, clinics and hospitals. His writings instead focus on the reasons why rural Haitians are impoverished and sick, describe their lack of access to medical and other basic services, and argue for the feasibility and necessity of providing such services. The services themselves, however, are only briefly described. The following text pertains to a PIH/ZL tuberculosis initiative:

> "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 against prevailing views that high-quality medical

services for life-threatening diseases in the context of extreme poverty are impossible to implement.

Farmer 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 communities where the group is active, particularly when one considers the paucity of health resources and infrastructure in settings like Haiti. Many of the complications that emerge from efforts to treat patients in Haiti (triage of patients, implementation of care, confronting local politics and bureaucracies) receive only minimal attention in Farmer's texts. 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 remunerated? 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, 2006). It is unlikely that such conflicts and tensions are absent from Farmer's medical practice and PIH/ZL's activities more broadly.

In Farmer's own writings, he makes little mention of Haitian health care workers, other than to emphasize that PIH/ZL works with dedicated health professionals and community health workers (*accompagnateurs*). Excerpts from

*Mountains Beyond Mountains* suggest a complicated relationship between Farmer and Haitian health professionals:

> In a bed by the door of the hospital lies a moaning thirteen-year-old girl, just arrived by donkey ambulance. Two young Haitian doctors—one is just an intern—stand beside her bed, eyes half-lowered, lips pursed, as Farmer makes the Haitian hand slap, saying, "*Doktè-m yo, doktè-m yo, sa k'ap pase-n?"*[sic]—Doctors, doctors, what's going on with you?" His voice sounds plaintive, not angry, as he lectures: You do not administer an antibiotic to a person with meningitis until you have done a spinal tap and know the variety of meningitis and thus which drug will work. Then he does the job himself, the young doctors looking on, holding the girl down. (Kidder, 32)

The climax of the anecdote is a few lines later, when Farmer says, "She's crying, 'It hurts, I'm hungry.' Can you believe it? Only in Haiti would a child cry out that she's hungry during a spinal tap." Later in the book, Kidder writes,

> "Haitian doctors, [Farmer] had long ago discovered, learned early to accept all sorts of deficiencies—shortages of medicines, filthy hospitals. Perhaps it is a universal tendency to view the deaths of strangers philosophically. Haitian doctors had better cause for this failing than most others in medicine. Not surprisingly, they tended to shrug when patients died from ailments like measles or tetanus or TB. Farmer had put some of his best efforts into teaching his staff to expect more of themselves (120)."

Elsewhere, writing about Haitian friends of Farmer who had died of preventable diseases, "Each friend had died while in the care of doctors, in the typical, substandard Haitian medical facilities that Farmer had come to loathe (107)." It appears that Farmer and PIH, like other foreign individuals and groups working to improve health care in Haiti, have ambivalent and conflicting views of and experiences with Haitian health care workers. On one level, the latter are criticized for their complacency and participation in an ineffective system that has failed to provide the most basic health services for the vast majority of Haitians, on the other hand, they are appreciated and valued for the contributions they do make and their potential to help enact the interventions that international aid

groups hope will improve the health of the Haitian poor. This paradox is central to my analysis of international medical aid in Haiti, and appears as a prominent theme in the following chapters of this dissertation.

Finally, in writings by and about Farmer, the populations he works with are characterized primarily by their poverty. This is particularly true in the case of Haitians. 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, Canada and elsewhere, who send remittances to family members in Haiti, remain involved in Haitian politics and continue to sponsor emigration. In addition, analyses of poverty that focus on per capita income or individuals' accumulated wealth and resources ignore the ways that a generalized lack of resources and infrastructure affects not only the poorest of the poor, but people in other social categories as well. The physicians, nurses, administrators, health agents, and other hospital employees I studied during my research lived in much better conditions than the patients that typically came to the hospital (and even better than those populations who didn't have the resources to access the hospital). Their lives, however, were marked by the challenges of living not only in communities with minimal infrastructure and public resources, but also by a growing sense of anticipation and dread at what Haitian author Edwidge Danticat has called the "unraveling" of their country (Danticat, 2008: 115). I would not advance the claim that a surgical nurse and a small-scale market woman experience equivalent levels of suffering due to poverty or structural violence, but it is clear that improving health for

Haiti's population depends in large part on the presence of an active and competent group of Haitian health care workers, and that these individuals' experiences and perspectives must be taken seriously.

It seems likely that Farmer's priorities as a physician (to provide health services to patients in need) precludes his capacity or willingness to provide an anthropological analysis of international medical assistance. His extremely demanding schedule of clinical and administrative activities may leave little time for research and publication, and research in this area may not be an interest or a priority. He may also 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, Farmer would certainly agree that the very fact that both his clinical practice and analyses are so innovative and so desperately needed speaks poorly of current global configurations of power, justice and solidarity.

## Chapter 2 "Working Together For Health" at the Hôpital Universitaire Justinien: Partnership and Persistent Gifts

L'Hôpital Universitaire Justinien (HUJ) is the largest hospital in northern Haiti, and the second largest in the country, after the Hôpital de l'Université d'État d'Haïti (HUEH) in Port-au-Prince. The HUJ was founded in 1890 by a group of wealthy citizens of Cap-Haïtien, who were influenced by French movements of the time that combined housing and care for indigents while removing them from public view (Constant, 1967: 4). Led by Justinien Étienne, the local postmaster, the group founded the Hospice Justinien on the site of the city's former colonial barracks. Situated on a slope not far from the Cap Haïtien's central cathedral and plaza, the site was favored for its breezy climate. The hospice's original building is still standing – a long building with a wide front gallery and graceful arches that houses the Internal Medicine Department. As when it was founded, it is divided into men's and women's wings by a small chapel in the center of the building. Many other buildings have been built on the hospital's grounds, including those that house surgery, obstetrics/gynecology, pediatrics, and the hospital's three small operating rooms. Efforts have been made to maintain the architectural style of the original hospice – arches and galleries have been incorporated into some of the newer buildings, and all are painted in the Asclepian colors of green and white.

In basing the bulk of my research my research at the HUJ, I chose a site that, like most health establishments in Haiti, has been shaped by decades of international involvement and intervention. This history is thoroughly described

by Paul Brodwin in the first chapter of his 1996 monograph on medical and religious pluralism in Haiti. Brodwin explores the history of Western medicine and biomedicine in Haiti, drawing on both primary and secondary sources to examine how international relations and medicine have been intertwined in Haiti and its colonial predecessor, Saint-Domingue. In particular, he examines how French and subsequently American military forces shaped the Haitian medical landscape. French colonial authorities established hospitals that served both to house and care for the sick and indigent among the European population in general, but that also attended specifically to the health needs of soldiers and military personnel. In addition, physicians were hired by plantation owners to treat African and Creole slaves in small plantation-based hospitals, although French doctors often abandoned medical careers in search of the economic advantages associated with participating directly in the colonial economy as plantation owners themselves. During the colonial period, health care for slaves was considered part of an economic investment in a labor force, and distinctions were made between more and less valuable slaves and the corresponding medical care afforded them. Both of these issues--how more lucrative opportunities attract clinicians away from medical work in Haiti, and the calculations and economics of care for an oppressed population in terrible living conditions – remain salient to this day.

During the American military occupation of Haiti, which lasted from 1915 to 1934, there were significant transformations in Haiti's health care system, namely the centralization of administrative structures (most obvious in the

establishment of the *Service National d'Hygiène et d'Assistance Publique*, which would go on to become the country's Ministry of Health and Population), the construction of hospitals and rural clinics, the influx of capital and technical expertise from the Rockefeller Foundation and the introduction of modern nursing to Haiti (Brodwin 1996). The occupation's accomplishments, failures and overall legacy would be contested by later analysts and historians (Heinl and Heinl, 1978; Castor, 1971; Bordes, 1992), but the US military's profound influence on the Haitian health care system is undeniable. While American Protestants missionaries had been active in the country since the late 19th century, bringing with them various forms of medical personnel, treatment, and supplies, the Marines opened up even more channels for other American groups and individuals to work on health issues in Haiti.[9]

While American initiatives have been prominent at the HUJ for most of the hospital's history, they have always been part of a larger web of international influence. Overseas Catholic religious communities (particularly those from Francophone nations and areas) have played a major part in the HUJ's establishment and functioning. As the Hospice was being created in the late 1800s, its directors called upon a community of French nuns, the Filles de la Sagesse (Daughters of Wisdom), to administer the establishment. Although some of the nuns were trained as nurses, they also occupied administrative and logistic functions: managing the laundry service and kitchen, obtaining materials and supplies, and keeping records. Their presence at the HUJ reflected a larger

[9]The HUJ had an American director from 1917 to 1934, and a plaque above the entrance of the surgery ward states that the building was inaugurated with funds from the American Red Cross in 1924.

pattern of Catholic orders' involvement in Haiti. Priests, nuns and brothers (particularly from France and Canada, but also the United States, Latin America and elsewhere) have been an important presence in Haitian health establishments, schools, and other institutions since the colonial period, and after the second half of the 19th century (the Vatican broke off ties with the newly-liberated Republic of Haiti for the first decades after its 1804 independence). More recently, French-Canadian orders replaced many of the French communities during the Second World War and the decades that followed it (Jackson, 2010). While there are still foreign Catholic priests, nuns and brothers working in Haiti today, the majority of these are in their sixties and seventies. Religious communities active in Haiti have been training young Haitians to take orders and assume leadership positions within their establishments, many of which are now completely Haitian-run. Oftentimes, the communities facilitate and fund training abroad for these Haitian clergy.

These larger patterns are visible in the HUJ's history: the French nuns who arrived in the late 19th and early 20th centuries were replaced by sisters from the community's Canadian branch in the mid 1900s, and subsequently by young Haitian nuns beginning in the 1960s. Many of the latter were sent by the order to receive medical and other training in Canada and France. Although their presence decreased both in administrative posts and in total number during the 1980s, the Filles de la Sagesse administrated the HUJ for over one hundred years. When I asked about the conditions of their departure from the hospital in 1993, I received many different answers, all of which provide insight into the politically-

charged relationship between the Haitian state, health care facilities, and religious communities. One physician told me that there had been an effort to "Haitianize" the country's institutions after the end of the Duvalier dictatorship in 1986, and that many foreign communities had been pressured to leave the country by various factions of Haitian society during this period. Another individual told me that during the coup years (1991-1994), the military government carried out violent and repressive acts against Catholic communities and institutions because of their association with deposed President Aristide. A Haitian priest told me that the nuns at HUJ left because of the rape and beatings of several nuns in Port-au-Prince: the Filles de la Sagesse and other communities purportedly left their establishments in protest. Finally, a nun who had worked at the HUJ for many years told me that even before the coup, Aristide's government had taken control of the Asile Communale in Port-au-Prince from the order, and since the nuns sensed their expulsion from the HUJ was imminent, they left preemptively. It seems plausible that a combination of the reasons listed above, rather than any single one, contributed to the Filles de la Sagesse's departure.

The recollections I heard from hospital employees and Cap-Haïtien residents about the nuns' presence at the hospital were nearly all positive, forming part of a larger body of nostalgic memories that recall more prosperous and orderly times (Glick Schiller and Fouron, 2001). They emphasized the nuns' operation of the kitchen and laundry services, two components of the hospital that are only minimally functional today: the laundry only washes surgical drapes and cloths, while the kitchen serves as a storage and distribution center for dry rations

donated by the World Food Program. Inpatients must now rely on their families and friends to provide them with meals and wash their bedding and clothes. In addition, the Filles de la Sagesse, like most Catholic orders in Haiti, had access to an extensive network of international funders and supporters from whom they could solicit resources, resources that were no longer sent to the hospital after their departure. The loss of international support that accompanies the departure of foreign religious communities has been noted elsewhere in Haiti (Paradis, 2005) Finally, Catholic orders are known by many Haitians for their "discipline" and "rigor," which for many of my informants explained their ability to maintain and sustain order in large institutions such as the HUJ. Their departure compounded the horrific effects of the American embargo, which lasted from 1992 to 1994, creating unprecedented resource scarcity and economic devastation (Farmer, 1994). In spite of expressing strong statements in favor of self-governance and identifying foreign interventions as responsible for many of Haiti's woes, most of the hospital staff also described the nuns' departure as being emblematic of the establishment's decay and decline in a broader context. These processes would be at least partially reversed by the arrival of a group of Americans in the year 2000.

### 2.1 Konbit Sante

When I interviewed medical staff at HUJ to talk about their experiences with international aid, they nearly always began by describing the work of Konbit

Sante, a small NGO based in the city of Portland, Maine.[10] The hospital's medical director often referred to this organization as "*nos partenaires privilégiés*," (our privileged partners) to signify the particular relationship that has developed between the hospital and Konbit Sante. Among other international aid initiatives, Konbit Sante was remarkable for a number of reasons:

1. An explicit decision not to provide clinical services by the group's American staff and volunteers: unlike most small, North American medical NGOs operating in Haiti, Konbit Sante itself carries out almost no clinical interventions. Instead, its main activities include implementing infrastructure projects, providing administrative support and material donations, and developing human resources through education and training.
2. The specificity and location of Konbit Sante's partnership: the group is only active in the Cap-Haïtien area, and the majority of its interventions take place at the HUJ. (Its second project site is the Hôpital de Fort-St-Michel, a smaller hospital located outside the center of Cap-Haïtien in a very impoverished residential area.) Most foreign organizations of Konbit Sante's size operate in rural areas or in Port-au-Prince, while larger organizations often work in multiple sites throughout the country.

[10] The term *konbit* refers to a traditional system of exchanging labor in rural Haiti, where peasants form groups to aid members with arduous agricultural work such as clearing land or plowing. *Sante* is the Creole word for health: the group translates its name as meaning "Working Together for Health." Creole names are popular among many international aid groups working in Haiti, whereas Haitian organizations often choose lengthy French names, which are generally shorted to acronyms.

3. The group's relationship to the Haitian public health system: since its founding in 2000, Konbit Sante has always worked in explicit partnership with Haiti's Ministry of Health (MSPP) and public health establishments, rather than with private hospitals or institutions. While they cooperate with other NGOs and some private healthcare centers, the group's commitment to working with MSPP is explicit. Many foreign NGOs operate autonomously from the Haitian government and are intentional in their efforts to avoid the latter.
4. The extent of Konbit Sante's involvement throughout the hospital: while many of the international bodies that are present at the HUJ focus on a particular sector or program at hospital, Konbit Sante is present in nearly every service. Certain services are the sites of more extensive interventions and partnerships (pediatrics is a notable example), while others (such as orthopedics) have been less so. However, the group's activity at the HUJ can truly be considered to be hospital-wide.
5. The diversity of the group's activities: drawing on volunteers from a variety of fields (medicine, nursing, engineering, education, architecture, and other fields), Konbit Sante's interventions in the hospital include the provision of medical supplies sent to the HUJ in large shipping containers from Maine; salary supplements for physicians to improve the quality of resident supervision; infrastructure projects to improve the hospital's electricity and water

systems; and seeking funding from outside donors to expand or renovate hospital buildings.

While Konbit Sante is in many ways an exceptional organization, examining discourses about the group (both by members and outside observers), the interpersonal relationships Konbit Sante creates and fosters, and its objectives, successes, and conflicts can all contribute to a better understanding of international medical aid in Haiti. Without discounting the specificities and local realities of each international aid initiative, an in-depth study of an organization like Konbit Sante provides insight into larger trends and patterns in aid. Specifically, it allows us to investigate forms of aid that are secular and self-reflexive; that draw from human rights rhetoric and models based on partnership and capacity building; and that represent emerging forms of international and global health interventions in the new millennium.

In many ways, this discussion responds to Fisher's 1997 call for anthropological studies of NGOs. He writes, "An enhanced anthropological contribution [to the study of NGOs] would enrich a literature the majority of which is replete with sweeping generalizations; optimistic statements about the potentials of NGOs for delivering welfare services, implementing development projects, and facilitating democratization." His observation that "[t]he often stated aim of 'doing good' is undermined by an inadequate understanding of what NGOs do in specific circumstances (Fisher, 1997: 441, 449)" is particularly relevant for my study.

While there is no doubt that NGOs are increasingly prominent, active and influential in diverse spheres, particularly in countries with weak governmental structures such as Haiti, I wish to call attention to two limitations of using "NGO" as a category of study. The first is the term's imprecision: by simply stating what an organization is not, the term NGO can be applied to organizations ranging from a major multinational agency that wields great influence and enormous resources to a small association of a handful of people, and anything in between. A university, the Catholic church, a sports team: all of these can be classified as NGOs, which may obscure more details than it reveals. Schuller (2009) describes the various characterizations of the term "NGO" by Haitian and foreign actors (44-46), illustrating discrepancies even in formal, codified definitions.

The second disadvantage of the term stems from the difficulty in distinguishing between the governmental and non-governmental dimensions in many organizations. Konbit Sante, for example, receives a significant amount of its funding from USAID; the same is true for many other "non-governmental" groups I encountered in Haiti. Some interventions were carried out by explicitly governmental groups (such as the Cuban health brigades), while Haitians health professionals involved in medical care routinely move between governmental and non-governmental establishments. In addition, international organizations may choose to work closely with the Haitian government. The adjective "non-governmental" in the context of international intervention generally implies the absence of the donors' government rather than the recipients'. It appears that an

increasing number of private international groups working in Haiti are seeking out collaborations with the Haitian government, including groups like Konbit Sante.

My contact with Konbit Sante began in the spring of 2006, during an exploratory trip to Cap-Haïtien. During my first visits to the HUJ, several members of the hospital staff mentioned the organization and its work. I ran into several members of the group at the Ministry of Health's offices in Cap-Haïtien, and had some preliminary conversations with their members in the days that followed. One of the people I spoke to during that trip was Dr. Michael Taylor, the founder of the organization, who immediately expressed interest in my work and openness to collaborating in my research. I traveled to Portland in the fall of 2006 to familiarize myself with the organization and meet its members. Throughout this process, the members and staff of Konbit Sante were extremely open with their information and generous with their time. I arrived in Portland to find that I had individual interviews scheduled with eleven of the group's members in their or Dr. Taylor's homes, was invited to an information session for new volunteers, and was given copies of trip reports, budgets, meeting notes, and other internal documentation. The group's members are open to and interested in outsiders' observations and perspectives, and my research and reflections on their activities were consistently met with interest and enthusiasm. This work has often felt like it is contributing to a pre-existing process of critical analysis rather than a covert investigation.

My choice to study the work of Konbit Sante was based not only from their extensive involvement in the hospital and the various opportunities their

diverse work offered for observation and analysis, but also resulted from my own interest in avoiding the exposé genre I described in the introduction to this study. Unfortunately, dramatic accounts of theft, graft, exploitation, ineffectiveness and abuse are often accurate portrayals of aid interventions in settings like Haiti (Wainwright, 2001; Schwartz, 2008), and it would not have been difficult for me to identify and study organizations in Cap-Haïtien whose work I could denounce. However, conducting research on Konbit Sante has involved trying to understand what happens when an organization comprised of thoughtful, committed and professional individuals from the world's wealthiest country set out to improve health conditions and outcomes in one of the world's poorest. The challenges and setbacks that Konbit Sante and the HUJ have faced during their work together are less indicative of Americans' or Haitians' personal moral failings than they are indicative of larger patterns and trends that lead to, accompany and emerge from health interventions across enormous socio-economic divides. Conversely, successes by organizations such as Konbit Sante should not be solely attributed to the will and skills of specific individuals, but also the result of structures and strategies that are particularly well-adapted to solving certain problems.

During my research, I found that the members of Konbit Sante tend to be quite self-reflexive, and that their interventions tend to be designed and implemented with great caution. More than most other groups I studied, its members frequently questioned the efficacy, impact and consequences of their interventions, both in dialogues with Haitian partners and amongst each other. As one volunteer told me, "I am always very afraid that I'm going to overstep my

boundaries, as somebody coming in." The group's executive director, Nate Nickerson, told me about an episode in the organization's early years, when volunteers obtained the donation of a large industrial washing machine, which they sent to the HUJ in a shipping container. The washing machine took an enormous amount of time and energy to procure, expedite and install, and in the end, was only used for several days before the hospital administration reverted to the original system of having hospital linens hand-washed by laundresses.[11] Nickerson told me, "Whenever people in Maine talk about a making a new donation or a new project, we always tell them about the washing machine, and the lessons we learned during that whole process." This self-reflection was not universally appreciated, as some volunteers occasionally complained about a lack of decisive action or the threat of becoming paralyzed by caution. It also happens that some of the group's projects, most often relatively minor interventions, are executed without an extensive attempt to understand the context they occur in or the ramifications that might follow. In general, however, the group carried out its interventions with caution and only after extensive consultations and conversations with the hospital's staff. Many of the group's projects were proposed by the HUJ staff, who regularly approach the group's members with requests for resources and support.

In the United States, Konbit Sante only employs three individuals: an executive director, an operations manager, and a program specialist. Dozens of

[11] I heard various reasons for the demise of the washing machine, include pressure from the laundresses who feared losing their positions and salaries, the unreliability of the hospital's power and water supply, and fears by hospital staff that the machine was incapable of thoroughly cleaning blood-stained surgical drapes and gowns.

volunteers contribute time and resources that are essential for the group's operation. The organization is directed by a board of approximately twenty members. Unlike organizations based out of Miami, New York or Boston, Konbit Sante does not rely significantly on the resources or participation of the Haitian diaspora. Most of its staff and volunteers are based in and around Portland, which does not have a sizeable Haitian-American community.[12] In Haiti, Konbit Sante employs approximately twenty-five individuals (all of whom are Haitian), including a program manager, physicians (whose primary duties involve both training medical residents and patient care), nurses, health agents, depot managers and support staff (including a bookkeeper, a translator and a driver).

Konbit Sante's Haitian staff members experience many of the benefits and drawbacks that are typically associated with working for an international organization in Haiti. Benefits include relatively high, consistently-paid wages, favorable working conditions, and contacts with foreigners that bring access to a variety of resources (including the possibility for travel abroad, English language practice, gifts of various sorts). Drawbacks include limited flexibility in terms of working hours (employees in the public system have high rates of absenteeism, which permits them to engage in other economic activities such as private medical practice or commerce), increased demands by members of kin networks who associate working for an international group with increased access to resources, and the difficulties of responding to the bureaucratic exigencies and regulations of foreign donors. Konbit Sante employees in Haiti also face the challenges of

[12] I am only aware of one Haitian-American employee and one Haitian-American volunteer who have been significantly involved with the organization. However, Konbit Sante does have strong working relationships with diaspora organizations and individual Haitian-Americans.

acting as intermediaries between foreigners and Haitians, positions that demand responding to diverse and sometimes contradictory demands and expectations.

**Eschewing the Clinical**

As mentioned above, a defining feature of Konbit Sante is its lack of emphasis on the provision of clinical services by foreign staff and volunteers. This is in stark contrast to many of the small North American medical aid organizations that send foreign teams to Haiti focus exclusively on carrying out clinical interventions. Foreign medical workers involved with these teams (including nurses, physicians, technicians and others) typically come to Haiti for a week to ten days every year to carry out various medical procedures and interventions. In rural areas with limited medical infrastructure, activities may include basic consultations, distributions of medications (such as analgesics, anti-hypertensives, and anti-helminthic medications), screenings and referrals for pregnant women, and wound care. In situations where foreign organizations are partnered with a Haitian health care establishment and more resources are available, teams may come to Haiti to perform specialized procedures on patients who have been pre-identified and pre-selected for operations.[13] Oftentimes, these organizations focus on a specific medical condition, such as cleft palate, club foot

5. This type of aid is common at the Hôpital Sacré-Coeur in the city of Milot, a private Catholic hospital located twelve kilometers (usually an hour by vehicle) from Cap-Haïtien. This hospital receives between twenty and thirty teams a year for week-long stays, including specialists in cardiology, orthopedics, urology and others. Most teams come from the United States, make an annual visit to the hospital, and stay in a nearby compound that also houses some of the hospital's full-time staff. Medical teams coming to the Hôpital Sacré-Coeur often carry out complex or specialized procedures that aren't normally available in northern Haiti – the hospital's full-time staff screens patients throughout the year to identify patients that would benefit from these procedures.

or cataracts. Konbit Sante is explicit in its choice not to carry out clinical interventions. In the "How You Can Help" section of its website, its "Volunteers" page opens with the statement:

> "Our model is different from many other groups in that we do not have regular volunteer positions/placements and our volunteers are not generally engaged in providing direct service while in Haiti. Instead, volunteers work in committees with staff and their Haitian colleagues to study needs, develop and implement initiatives, conduct trainings, make infrastructure improvements, and deliver much-needed equipment and supplies."
> (http://konbitsante.org/get-involved/haiti-volunteers)

The group's members are similarly explicit in describing the group's relation to clinical services. As one volunteer told me: "In contrast to many other groups that go to Haiti, and that have an approach of going to take care of patients, that's not what we're about. We are trying to help build — build a health system."

I was told several times by personnel at the HUJ that the hospital did not host visiting teams of specialists because there was no designated lodging for them.[14] Many foreigners volunteering or working at the HUJ (including all of Konbit Sante's members) lodged at the Hostellerie du Roi Christophe, a historic hotel located a 20-minute walk from the hospital. "The Christophe" as many guests refer to it, is one of a handful of higher end hotels in Cap-Haïtien, and while Konbit Sante had developed ties with the owner through their years of frequent patronage that gave them access to discounted rates, the room charges of 40-60 USD per person (not including meals) represented a significant expense for

[14] During my research, the HUJ received only one team carrying out regular, short-term clinical interventions: an orthopedic surgeon employed by CURE International (an American NGO) and based in Santo-Domingo traveled to Cap-Haïtien every three months to carry out orthopedic surgeries. Accompanied by Dominican and American physicians, nurses and technicians, he would recruit and select patients on the first days of his trip, and for the following four or five days, carry out a high number of surgeries, operating as many as 20 hours per day. More information on these interventions is presented in Chapter 4.

foreign teams, particularly those working on more limited budgets. (These prices, of course, are astronomical when juxtaposed with Haitians' average daily revenue of less than 1$ per day.) The HUJ's inability to house foreign medical teams is an example of the ways in which Haitian institutions have or lack the capacity to "absorb" outside resources. Foreign groups travelling to volunteer in Haiti often highlight the need for secure lodging and access to safe food and water, all located near their site of intervention. International groups usually associate such accommodations with private and religious institutions in Haiti.

While the decision not to directly provide clinical interventions is a key part of Konbit Sante's identity as an organization, it is also the cause of confusion to outsiders. Nate Nickerson told me that he spends a lot of time explaining this model to people both in the United States and Haiti, who, according to Nickerson, "don't always know how to categorize us." It is clear that most small NGOs that send a significant number of volunteers to Haiti (as does Konbit Sante) tend to focus on service provision. Konbit Sante, in its efforts to "work with existing structures to strengthen available health resources" not only challenges widespread assumptions by both Haitians and Americans that foreign medical professionals in Haiti are there to provide clinical services, but also engages in activities that do are not often measurable using funders' metrics and scales. Nickerson often told me that "funders want to know how many 'widgets' you've given out—we just don't work that way, and they don't know what to do with us." "Widgets" might refer to vaccines, eyeglasses, HIV therapies, crutches, or any of the many other countable items that are dispensed by most aid groups in

Haiti. Although Konbit Sante does provide the hospital with tangible material goods (discussed below) and while many of its non-clinical interventions do have some quantifiable dimensions (for example, paying the salary of a physician who oversees the training of sixteen medical residents), many of its activities are difficult to convey in a domain where clinical services have historically been and continue to be the currency in which interventions are measured and evaluated. Conversely, this approach has also won the group supporters, particularly individuals who for varying reasons are critical of existing patterns and models of international medical aid in Haiti and wish to invest in alternative strategies, such as those proposed by Konbit Sante.

Konbit Sante's members' decision to avoid creating what they term a "parallel health system" involves a commitment to work closely with the Haitian government (specifically the Ministry of Health). This commitment reflects the group's support for public health care, and is possible in great part because of Haiti's political environment over the last two decades. Haiti has had a democratically-elected government for fourteen years of the past sixteen years. While there has been controversy about the specifics of elections, the legitimacy of parliament, and the role of the UN stabilization force in the country, governance in recent years is substantially different from the Duvalier-family dictatorship (1957-1986) or the years of instability, military coups and multiple configurations of government that immediately followed it (1986-1990, 1991-1994). Since Konbit Sante started working in Haiti in 2000, there have been three separate administrations (Jean-Bertrand Aristide's second presidency from 2000

to 2004, an interim government from 2004 to 2006, and René Préval's second presidency from 2006 to 2011), which represents a relatively low rate of turnover both at the national level, and in terms of local leadership at the Ministry of Health's northern office and in the HUJ itself. For international organizations with longer histories in Haiti, memories of operating in the context of the dictatorship (which involved intimidation by paramilitary thugs and the extortion of bribes by Duvalierist cronies) and constant military coups may make the idea of partnering with the Haitian government an unappealing prospect.

I now turn to two case studies that illustrate Konbit Sante's projects and programs: the group's interventions in the HUJ's pediatric and nursing departments.

**The Pediatrics Partnership**

The pediatrics service at the HUJ consists of six inpatient rooms divided by patient age (neonates to adolescents), an outpatient clinic, and a malnutrition clinic (the latter two each consist of a single, small room). The service has an official capacity to intern approximately sixty patients, although it is not uncommon to find more than one patient in a bed. The service officially employs nine attending physicians, twenty-three nurses and auxiliaries and fifteen support staff, although many of the attending physicians rarely come to the service (absenteeism is less common among nurses and other staff.) Sixteen residents account for the bulk of physician presence in the service. Most pediatric patients are accompanied by at least one family member, who provide food, bedding, and

who often sleep on the cement floor next to the patient's bed. It is not unusual for there to be an abandoned patient in at least one of the rooms—poverty and desperation often drive parents or relatives to slip out of the service during the night, leaving the young patient dependent on the compassion of the medical staff or the other families nearby.[15] Because of the difficulties and costs involved in coming to the HUJ, which often include traveling great distances, sacrificing income-generating activities, and paying for consultation and medications at the hospital, parents are often unable to bring their child to the hospital, or delay seeking treatment until the sickness has reached an advanced stage. Pediatric patients at the HUJ suffer from the largely preventable pathologies that afflict children throughout Haiti: diarrheal diseases, respiratory infections, malnutrition and infectious diseases (EMMUS-IV, 2007).

Pediatrics is the service at the HUJ where Konbit Sante has been the most active. This can be evaluated by the scope and quantity of resources dispensed, the number of volunteers involved, and the frequency of meetings and interventions with members of the service. A key component of Konbit Sante's work in the pediatrics service involves medical residents. When the organization began its work at the hospital, a single resident was being trained in pediatrics. This was unanimously attributed to a lack of training and mentorship available from staff physicians, who, as mentioned above, demonstrate high rates of absenteeism. With no staff mentors, set curriculum, or specific training opportunities, pediatrics at the HUJ had limited appeal for medical students

[15] These children may eventually be referred to local orphanages, be adopted into a family seeking a child, or face lives of forced domestic servitude (the infamous Haitian category known as *restavèk*) and other forms of exploitation.

choosing residency programs. In 2005, Konbit Sante agreed that it would supplement the salary of a staff physician who would be responsible for and take an active role in training residents. By the time I completed my research at the HUJ, the number of residents had grown to sixteen, and a second physician had been hired by Konbit Sante and the hospital to help train the residents. Other pediatric health workers employed by the organization include a nurse educator and two community health agents who provide follow-up care and visits to infants discharged from the HUJ's pediatric inpatient malnutrition program.

Konbit Sante's interventions in pediatrics also include tangible forms of material assistance. The organization funded the remodeling and renovation of the pediatrics conference room, where morning reports, residents' academic presentations, and other meetings take place. Konbit Sante procured and delivered all of the furniture in the room (used but functional tables, chairs, and shelving from hospitals in Maine), as well as a variety of textbooks, a television monitor, projector, and computers. In the pediatric intensive care units, Konbit Sante installed the tubing and spigots necessary to provide oxygen to multiple infants, replacing the previous system where infants received oxygen directly from a single tank.[16] In addition to renovating and developing existing spaces, Konbit Sante solicited funds from outside donors to build a pediatric outpatient consultation room, and most recently, a pediatric emergency room. An excerpt from the head pediatrician's speech at the room's inauguration hints at both the

[16] Infants' parents or relatives are still required to purchase tanks of oxygen from a vendor outside the hospital.

appreciation HUJ employees feel for Konbit Sante and the expectations they have for future support:

> "They do not come as conquerors. They don't impose any orders, any pre-existing conditions, any constraints. The name they have chosen for their organization is telling. Konbit Sante favors the effective participation of all actors involved in a colossal collective work. Success on the ground and good results are their only motivations and often the only guarantees that they require from their partners. We must come together to achieve a single and essential goal: health in all its dimensions. As proof of this philosophy, this approach, this room will allow us in pediatrics to improve and modernize the quality of the care we give. An emergency room today, soon an intensive care unit, a neo-natology service, a dormitory for the patients' families…"

This physician is well known among Konbit Sante's American staff and volunteers for his many and repeated requests for aid for the pediatrics service. Some who were present for the speech chuckled at hearing the proposal for new projects that accompanied the appreciation for one which had just been completed.

Haitian and American participants in Konbit Sante's activities offered several theories to explain the group's marked presence and success in the pediatric service. Foremost among these was that donors are particularly moved by and likely to intervene on the health needs of children. This theory (which I can support with evidence from various aid organizations and agencies) explains the strong presence of Konbit Sante and other international groups in pediatrics as compared to urology and dentistry. Such tendencies appear to be indicative of larger patterns: Bornstein (2010) has described the significance of children, particularly orphaned children, in humanitarian discourse. Similarly, Malkki (2010) claims that the figure of the child does "ritual and affective work [in] transnational representational spheres (59)," including its embodiment of human goodness and the future, and in its role as a prototypical sufferer.

Another factor has been the personalities and characteristics of the individuals involved in the partnership. As mentioned above, the head of the pediatric service has been consistently eager for new collaborations and projects: his demeanor towards foreign partners is friendly and enthusiastic, and he regularly presents long lists of needed materials, renovations and constructions to Konbit Sante and other potential donors. On the American side, several pediatricians and pediatric nurses have been particularly active in traveling to Haiti and procuring donated materials, supplies and funding from American health establishments and donors. Despite Konbit Sante's efforts to work throughout the hospital's various departments, the inception and success of its activities often depend heavily on the interests and availabilities of its American members. In some cases, however, even interest and availabilities aren't enough to secure a successful partnership. This was the case for the hospital's nursing service.

**The Nursing Partnership**

Over the years, Konbit Sante has developed a model of partnership in which health professionals from Maine approach personnel from the corresponding medical specialty at HUJ and initiate dialogue that they hope will lead to fruitful collaborations.[17] Nurses have been prominent and active in Konbit Sante since the organization's inception. The organization's current executive

[17] In one case – surgery – HUJ staff approached Konbit Sante members to initiate a partnership. While visiting Konbit Sante staff and volunteers are regularly solicited for different forms of immediate and often individual aid, this request was formulated as an official institutional partnership for the surgery service, similar to those established with other services, and did indeed lead to a formal partnership with Konbit Sante and surgical professionals at a Portland hospital.

director is an RN, and asserts this occupational identity proudly. Nurses are also active on the organization's board, in its various committees, and are nearly always present during group trips to Cap-Haïtien. In 2006, several nurses in the organization began considering the possibility of developing a formal partnership with the nurses at the HUJ. From conversations with nurses and other hospital staff, they concluded that nurses at the HUJ shoulder heavy responsibilities, are under-paid and under-appreciated, and face some of the similar inequalities in status and power vis-à-vis physicians as do their American counterparts. In addition to reporting to the director of their respective services, nurses at the HUJ work under the supervision of a head nurse in each service, who in turn report to the director of the "Bureau de Nursing," a nurse named *Mis* Louis.[18] In planning to establish a partnership with the nurses at the hospital, the American nurse members of Konbit Sante approached Mis Louis and the other members of the hospital's administrative council. Reactions to the original proposal were positive, and meetings between the American and Haitian nurses were planned for dates when the American nurses would be in Cap-Haïtien.

I sat in on several of these meetings, which usually included Mis Gonel, the executive director of Konbit Sante, two or three American nurses and the head nurses from various departments throughout the hospital. Almost all of the ten departments were represented, and those who were late were called by their colleagues and encouraged to hurry. In all of the meetings I attended, the format was similar: the Haitian nurses were asked to describe what they envisioned a

[18] *Mis* is both the word for nurse and the title used to address nurses. The term's origin reflects the influence of the 1915-1934 US Marine occupation, which brought modern nursing as an occupation to Haiti.

partnership with Konbit Sante might look like, and what the organization could do to make their work easier. The Haitian nurses' discourses were fairly consistent, and focused on lack of medical materials, understaffing, and problems with material infrastructure such as electricity, water, and space. The American nurses acknowledged these challenges, but from prior conversations with them, I knew that they did not want to focus on the provision of materials or supplies, and did not want to add major infrastructure projects to those already undertaken by the organization. During the meetings, the tension was palpable. The Haitian nurses sat with their arms crossed, looking at the floor or at the desk in front of them. The American nurses leaned forward, anxiously listening and looking for signs and communication. All comments were translated between Creole and English either by myself or by Konbit Sante's regular translator, which added to the length of the meetings. The meetings ended on a note of uncertainty, with promises to follow up on specifical procedural items, but no conclusive agreements about projects or activities that raised enthusiasm of the participants.

After one of these awkward encounters, one of the Haitian nurses who had a positive rapport with members of Konbit Sante and believed that the American nurses were acting in good faith told me, "They should stop pushing so hard. The nurses here will think that they're getting money to work with us, and that's why they're so insistent on developing a partnership." Ironically, it was the American nurses' sense of professional solidarity with their Haitian counterparts and their strong commitment to establishing a partnership with them that made them seem suspicious to the Haitian nurses. This was not the first or only time I encountered

Haitian recipients (active or potential) who interpreted donors' zeal or insistence as evidence of an ulterior, self-interested motivation for providing aid. The donors were rarely aware of such interpretations, and if they did become aware of them, some concluded that Haitians "do not understand altruism."[19]

After several meetings in Haiti, discouraged by the lack of enthusiasm or initiative by the Haitian nurses and at a loss for what a potential partnership could involve in concrete terms, the American nurses set aside the project for a nursing partnership between Konbit Sante and the HUJ. While both Haitian and American nurses continue to play important roles in the organization and its programs, a formal partnership centered on nurses does not seem likely in the near future.

The differences in outcomes between the pediatrics partnership and the nursing partnership have multiple causes. As opposed to pediatrics, which is a specific department that is structured by a single hierarchy and operates within a clearly defined physical space, nursing is diffused throughout the hospital, and is not as united by physical or hierarchical structures. In addition, it is more difficult to garner international support and resources for nurses than for infants and children. A final factor is the role of material gifts in the two partnerships. I now explore some of the reasons why, despite Konbit Sante's minimization of material donations in their work, gifts remain persistent as objects that can both help facilitate international medical interventions and exacerbate inequalities.

[19] The Konbit Sante nurses never expressed this idea – I don't believe that they interpreted the Haitian nurses' suspicion as a questioning of their motivations or intents, but rather as skepticism that changes were possible.

**Persistent Gifts**

When I asked the HUJ's staff to describe Konbit Sante's activities, they almost always began by telling me that the organization regularly sent large shipping containers of medical supplies, materials and equipment to the hospital. The containers, which are shipped from Maine to the port of Cap-Haïtien and transported into the hospital's main courtyard by truck, are a visible and tangible marker of Konbit Sante's support for the hospital. Common items in the containers include boxes of donated medications, medical equipment, electrical and plumbing supplies, and furniture. While other organizations ship containers to the HUJ on an occasional or sporadic basis, Konbit Sante's containers are more frequent and regular than other groups', generally arriving at least twice a year. The containers garner particular enthusiasm in Maine, where volunteers gather to sort supplies and load the container in a collective effort. Preparing these containers has been the subject of newspaper articles in Portland and essays on Konbit Sante's website, texts that are nearly always published with an accompanying photograph of volunteers loading the container.

Figure 2.1 HUJ employees and Konbit Sante volunteers unload medical supplies and equipment from a shipping container. Fall 2009. Photo: unknown.

Over time, preparing, shipping and unloading the containers has become easier for the organization to manage. Nate Nickerson described the first container to arrive at the HUJ, which took several days to unload, and attracted a large number of men (not all of them hospital employees) who unloaded the items from the container and then expected to be paid for their work.[20] Since it has become known that unloading Konbit Sante's containers is not paid work in and of itself, Nickerson reports that few if any workers come to help unload them. Nonetheless, the process now takes much less time than it used to, as the hospital's newly inaugurated depot is prepared to receive donated goods. Other

[20] With the undermining of Haiti's agricultural sector by neo-liberal trade policies and limited opportunities in construction, skilled trades or the service sector, work unloading containers (often filled with subsidized agricultural products or donated second-hand goods from abroad) represents one of the few remaining income-generating activities available to men in Haiti. The physical tolls of this type of work (hernias, sprains, accidents, etc.) are significant.

mechanisms for distributing donated goods have developed over time — for example, if items in the container have been specifically donated for a certain service, that service will generally send staff to retrieve the items and bring them to the proper location).

In addition to the containers, the depot is a highly visible site of Konbit Sante's interventions. The structure was built in 2007 by the government of Haiti (with funding from USAID), and consists of a 1500- square-foot storage space and a small office for the depot manager. Not long after the new depot was built, Konbit Sante equipped it with donated metal shelving units, and hired a manager who would be responsible for organizing the material, keeping track of inventory, and approving requisitions from hospital staff for needed materials and medications. Hospital staff and Konbit Sante describe the previous depot in unflattering terms: supplies were stored in disorganized heaps in a small room, it was never clear who had the depot key, and requests for materials were often unfulfilled. There appeared to be no oversight in terms of what came in or out of the depot, and many items were discarded after reaching their expiration date or sustaining physical damage from the conditions in which they were stored.

While the new depot was universally described as an improvement in comparison with the previous system, problems persist. Medical staff members complain that the materials they need are not always available, or that the depot's non-medical personnel aren't familiar with specialized pharmaceuticals or equipment, and don't dispense them if they are requested by another name or brand. Some complain that the requisition process is too lengthy (a designated

member of each service's staff is supposed to fill out at requisition form, drop it off at the depot, and return to retrieve the requested items). Certain members of the HUJ staff, particularly those in more senior medical positions, have taken to hoarding stocks of supplies in their own departments for greater autonomy.

Nevertheless, there is a regular stream of supplies in and out of the depot, and the hospital's administrative staff told me that their likelihood of attracting donations has increased tremendously now that they have a secure and controlled space for storing them. During my field research, the frequency of container donations did appear to increase significantly, and at times, the depot manager was at a loss for where to store the increasing amount of supplies. In cases where it seemed as though medications and materials would expire before being used at the HUJ, the depot manager would contact clinics and hospitals in the surrounding area to distribute the excess. This informal arrangement highlighted the importance of interpersonal networks for resource distribution in Haiti, and exemplified a situation in which individuals such as the depot manager could be accused of favoritism, pilfering resources or diverting donations. She herself often hinted that she experienced a great deal of "pressures" from others due to her position, but would not elaborate.

Despite the limited emphasis their organization officially accords the provision of material goods and supplies, I was struck by Konbit Sante members' enthusiasm for and involvement in the containers and the depot while volunteers were in Haiti. American volunteers often would spend time in the depot during times when they were not occupied by meetings, training sessions or site visits.

They often expressed to me that working with supplies gave them "something concrete to do," and at the end of a sometimes frustrating day involving inconclusive meetings, delayed appointments or various logistical obstacles, it was not uncommon to hear volunteers make comments such as, "Well, at least we got those boxes of medications sorted." Activities related to material aid could involve sorting newly-arrived donations, classifying or rearranging stock on the shelves, moving items to ancillary storage spaces or just tidying up.[21] (I experienced this appeal firsthand, and found myself wandering to the depot during quieter times during my research, wanting to see what donations had been donated by which organizations, chatting with the depot staff, and observing how they were developing systems for organizing and distributing material.)

There are various factors that help explain this persistent concern for and interest in tangible and material forms of aid. Like many other foreigners, American members of Konbit Sante (particularly on their first visits to Haiti) were struck by the lack of physical resources at the HUJ and other health care establishments. Many would make comparisons to conditions in the hospitals and clinics where they worked in the United States, comparing scarcity and resourcefulness in Haiti to abundance and waste in their own workplaces. Konbit Sante volunteers commented spoke extensively and emotionally about the scarcity and lack of diversity of medications, medical materials, and medical equipment, often naming specific items which were absent ("They don't even have a refrigerator for medications that need to be kept at lower temperatures!") or out of

[21] Deforestation, erosion, and unpaved roads contribute to a major dust problem throughout Haiti, and even objects stored in closed spaces are quickly covered with a thick layer of grime.

date by American standards ("We used to use that kind of autoclave when I started working thirty years ago, but they're completely obsolete in Maine now.") While the volunteers recognized and praised Haitian medical staff's ingenuity, resourcefulness and careful management in a context of limited or absent resources, all parties involved identified the latter as a major obstacle to providing high-quality medical services.

Another factor that made material forms of aid particularly seductive to American volunteers was that much of the work related to material donations did not require Creole or French language skills, or extensive negotiation. As opposed to meetings or discussions where personal contacts were often mediated through translators and painfully slow, Konbit Sante could and did interact with material goods alongside non-English speaking HUJ employees using non-verbal communication, or without communicating at all. The supposedly redemptive qualities of physical labor are highlighted by the many aid groups that organize trips to Haiti and elsewhere for North Americans to build homes, paint schools, and renovate churches. While often described in glowing terms by the volunteer participants, these encounters do little to provide employment to Haitian carpenters, masons, or laborers. This model of aid is very different than the one promoted by Konbit Sante, but an enthusiasm for concrete interventions involving physical labor is nevertheless present among members of the group.

Those Konbit Sante volunteers and staff who had greater experience in Haiti, however, especially those who had assumed leadership positions in the organization, more often commented on resource scarcity as a systemic problem

involving prioritization, organization and distribution. In this discourse, they echoed the commonly-heard refrain among Haitians that Haiti is rich, and that this richness has not been utilized. In contrast, however, members of Konbit Sante were more likely to talk about "weak systems" or "structural problems" than Haitian hospital employees, who more often attributed resource scarcity to specific human failings such as incompetence, greed, lack of *konsyans* (conscience or awareness), and *mechanste* (meanness). Among members of other foreign aid groups, it was comments to hear complaints about "corruption" in Haiti, particularly in terms of the Haitian state, even though those making the accusations often had had no direct contact or experience with government workers or structures.

**Recipients' Perspectives**

As I mentioned above, material donations were usually the first of Konbit Sante's interventions to be mentioned by Haitian informants in their descriptions of the group's activities. This type of aid was particularly visible and obvious, as containers enter the hospital through its main gates before being placed in the central courtyard for unloading. In addition, donated materials, equipment and furniture often appeared throughout the hospital, and often bore insignia or labels from its donor institution in Maine. Depot staff often wrote "HUJ / Konbit Sante" or simply "K.S." on items such as chairs or shelves in black permanent marker. Many of Konbit Sante's other activities (such as meetings) took place behind closed doors, either in the group's small office on the hospital grounds or in other

administrative offices. While residents in pediatrics and internal medicine were aware that their physician supervisors were paid by Konbit Sante, they were not aware of the specificities of the arrangement. As Konbit Sante members interact primarily with upper-level staff at the HUJ, the only contact that individuals such as janitors, porters, technicians and patients would have with the organization would be through donated goods.

The tangible dimension in and of itself of items such as bandages, pharmaceuticals, crutches, chairs and surgical instruments has a specific advantage, according to many HUJ employees. Tangible objects with an immediate purpose are less ambiguous in function than cash, and more enduring in presence than training or procedures. The flexibility and mutability of cash allows it to be used for unexpected expenses, or re-directed in cases of surplus, but also makes it easier for the donation to "take the wrong path" (*faire fausse route*), as my informants frequently observed. The notion of a false path for a donation implies the existence of *a* correct path, that aid has a singular and appropriate destination. In the discourse of my Haitian informants, monetary aid is particularly unlikely to make it down this path. In their words, "the people who need help the most don't receive it." The evidence for this is all around them – sick children, families living in squalor, and beggars in the street are all evidence of aid that failed to reach the appropriate recipients.[22] While non-cash items could be sold or exchanged illicitly, the additional procedure that this would

[22] Informants were wary of pointing to specific instances of aid that was diverted or misappropriated, although one common complaint was that a great deal of aid funds were spent on expensive and useless "*séminaires*," trainings or workshops, which were held at exclusive hotels in Port-au-Prince or at beach resorts.

require and the increased chances that the transaction would be exposed made donations of materials, equipment and supplies among the "safest."

Some of the group's American staff and volunteers were aware of the prominence material donations had in the eyes of the HUJ's staff, and at times found this to be disconcerting. Unlike other organizations for whom material medical aid is a primary activity and reason for existence,[23] Konbit Sante always lists activities related to donations and supplies low on their descriptions of programs, after activities such as training, administrative support, infrastructure programs related to water and electricity, and research. The group presents these activities within the larger framework of "capacity building," a concept that emerged within the UN system and financial institutions such as the World Bank and the IMF in the late 20th century. Capacity-building minimizes the provision or donation of material goods, and instead emphasizes restructuring organizations and value systems, and developing human resources (Wubneh, 2003). Not only do Konbit Sante members feel that attention to material donations may distract from their primary objectives and strategies, but are also concerned that tangible forms of aid to one of the hospital's services will be noticed by members of other services and attract even more solicitations or resentment in cases of refusal. The members of Konbit Sante are accustomed to regular and repeated solicitations for diverse forms of aid, from individuals, groups and organizations. Nickerson commented to me that it sometimes felt like he spent most of his time in Haiti fielding and turning down requests. Despite their frequency and familiarity,

[23] Direct Relief International is such an organization that is active at the HUJ.

solicitations of aid remain unsettling for members of Konbit Sante, and many describe them as the most difficult aspect of spending time in Haiti.

Conceptualizing Konbit Sante's activities in terms of gift theories makes visible some of the specificities of the group's approach and interventions, as well as some of the larger trends and characteristics of international medical aid more broadly. Even if Konbit Sante's interventions in the HUJ did not include any material components, they could still be classified as gifts according to Mauss' classic definition, which includes intangible services as well as goods (Mauss, 1990: 3-7). Because goods and tangible objects have eclipsed conceptions of services as gifts not only in academic literature but also in popular understandings of the term, I suspect that most members of Konbit Sante would not think of trainings for health agents or analyses of the hospital's water supply as gifts. Gift-giving also creates categories of givers and receivers, which contradicts the group's emphasis on partners and colleagues. Nevertheless, gift language permeated the descriptions of even their most intangible interventions: "to *give* them the tools to be self-sufficient," "to *provide* support for hospital staff," "to *contribute* to infrastructure in Haiti." The equipment, supplies and pharmaceuticals sent to the HUJ are even more obviously classifiable as gifts by both Americans and Haitians, although the word "gift" was almost never used: "donation" was the term of choice.[24]

Mauss categorizes giving, reciprocating and receiving as obligations, and describes situations in various societies where these obligations help ensure

[24] *Don* ("donation" or "gift" in both French and Creole) was used by Haitian informants. At times, the Creole term *kado* (from the French *cadeau*, or "present") was also used.

harmonious social relations within and between groups. All three obligations are described, enforced and contested differently depending on the models of giving and values present in a given society. Elsewhere, I have described the tensions related to giving that emerge out of two distinct (but increasingly overlapping) rhetorics involved in the provision of care to Haitians at a Dominican border hospital (Minn, 2010). In a humanitarian rhetoric, aid results from a donor's will to give, and can be stopped or rescinded at any time. In human rights rhetoric, providers are obligated to aid a patient in order to protect the latter's human right to health: withholding aid could constitute a human rights violation. Although Konbit Sante members support and promote the idea that health is a human right (this position is the first item on the group's "About Us" page on their website), they, like Farmer, do not make an explicit link between Haitians' right to health and their own obligation to provide health services. Their choice of Haiti as a site of intervention did not stem from a prior relationships or a sense of obligation based on kinship or nationality, as is the case for many Haitian diaspora groups. Rather, the group chose Haiti because of its proximity to Maine (initial efforts to work in Africa were abandoned because of distance) and because it was there that they saw "the greatest need." I never heard that group's members speak about their activities in Haiti in terms of an obligation to give, however they did use the term "give back," an expression that implies reciprocity, which I will discuss below.

Konbit Sante members spoke about an obligation to receive which became apparent not long after the group began intervening at the HUJ. This involved

group members offering a resource or service, which would be accepted, often eagerly, by hospital staff. On subsequent visits, however, group members would notice that the intended resource or service was not being used, and in the case of physical objects, was often collecting dust in a storage space. This created speculation among American staff and volunteers about the reasons for what appeared to be a blanket acceptance of all offers. One told me, "Even though they said that this was going to be helpful, it's in the discard pile. And we'd love to figure out a way to work with our Haitian colleagues to get to a more candid appraisal of things that they really don't want." When I asked him why he thought such an appraisal was difficult to obtain, he replied, "It's very hard to say no to your uncle, to your rich uncle that brings you all this stuff. […] Maybe he won't bring you anything." Another volunteer used the phrase, "You don't bite the hand that feeds you," confirming that some American informants were aware of the power differentials that exist between donors and recipients in such transactions. While both American and Haitian informants pointed to some pragmatic reasons why aid was seldom refused (i.e., the aid might not be useful at the time of donation, but a corresponding need could arise with time; an item that wasn't particularly useful could be disassembled for parts and materials), a key factor identified by all informants was that a refusal could decrease the likelihood of future offers of aid, either because the donor might assume that the recipient was not, in fact, needy, or because once an alternate recipient had been identified for the rejected gift, the channel of aid might be diverted away from the original recipient. While they usually did not make these reflections explicit in their

interactions with each other, many of the Konbit Sante members and all of the hospital staff I spoke with about these issues recognized that the obligation to receive was central to perpetuating gift relations.

Finally, the obligation to reciprocate is the most contentious in the aid I studied. At first glance, Konbit Sante's interventions in Haiti, like those of many international medical aid groups, can be interpreted as unreciprocated gifts. Whether the aid takes the form of material donations or of transfers of expertise or models in the framework of "capacity building," the most obvious flow of goods and resources is from wealthy countries toward Haiti, with no obvious reciprocal counter-gift. It would be difficult to conceive of the Haitian government or Haitian organizations sending medicine or supplies to the United States, Canada or France. That being said, reciprocity (or a lack thereof) should not be dismissed as irrelevant to this analysis, as it was a central (if not always explicit) theme in many of the discourses, actions and relationships I observed among both Haitian and non-Haitian participants in international medical aid.

One manifestation of reciprocity appeared in the discourses of Konbit Sante volunteers and other North American medical aid volunteers who said that their activities in Haiti were a form of "giving back." This expression was used by individuals who may never have been to Haiti and often had no prior relationship with Haitian people. When asked to elaborate what they meant by giving back, informants told me that they felt that they had received a great deal in terms of opportunities, resources and good fortune, which let them enjoy a high quality of life. They understood their activities in Haiti to be an appropriate

response for someone in their position. By framing them as "giving back," the volunteers did not assume that impoverished Haitians were the source of their own successes and comfortable lifestyles, rather they felt that they had been blessed or favored by a non-specific force or configuration such as "fate" or "being born in the right place at the right time." Work in Haiti reciprocated these gifts of ambiguous origin to people who desperately needed the counter-gift. While the volunteers could (and did) "give back" through various activities in their home state of Maine, work in Haiti is particularly satisfying for Konbit Sante volunteers because of the enormous needs they identify there.

Another commonly-used phrase that suggested the salience of reciprocity among Konbit Sante members and other North American aid workers was "I get so much more out of doing this than I give." This phrase was most often used when responding to praise by observers for the speaker's work or volunteering in Haiti. When asked about what it was they "got" out of doing aid work, responses generally revolved around a sentiment of contentment and satisfaction of being able to help others and "accomplish something." One described the feeling associated with working in Haiti as a drug: "Once you start, you get hooked!" Many appreciated the contact they shared with Haitian colleagues and the relationships they had built with them over time. Some mentioned enjoying the opportunity of seeing another country and lifestyle, although witnessing poverty and pathology for Haiti also represented a source of pain and negative emotions. In many cases, however, it seemed that saying they got more than they received from working in Haiti was a way of deflecting praise and admiration from others.

Whether because of social conventions that require modesty from the doers of "good deeds" or because of a discomfort with what might seem like excessive adulation for an activity that has become a routine part of their lives, bringing reciprocity into play allows aid workers and volunteers to avoid characterization either as selfless and altruistic (terms most aid workers I met did not identify with) or as the magnanimous distributors of unreciprocable gifts, complete with the discrepancies in power that accompanies this role.

A final manifestation of reciprocity in the work of Konbit Sante and other international groups working in Haiti involves the emigration of Haitian medical staff to the countries where most the bulk of aid originates, specifically the United States, Canada, and France. The experiences and relationships these health professionals have with international aid bodies is the subject of the following chapter; I will simply mention here that these professionals' immigration to aid-sending countries could be framed as a form of reciprocity, in which Haitian professionals return the gift of training and employment in Haiti with migration to and service in the sending country. I was frequently told that employment with an international organization often acts as a stepping-stone toward immigration. This was the case for Dr. Gilles, who was Konbit Sante's in-country Program Manager when I arrived in Haiti. A Haitian-trained gynecologist, he also had an MPH from an American university and spoke fairly fluent English. After working for Konbit Sante for several years, he immigrated with his family to

Montreal, where he found a job doing manual labor in a food-packing plant.[25] He continues to hope that he will be able to find work in the health care sector.

While this type of immigration could be interpreted as reciprocity, it was never framed as such by any of my informants. Rather, emigration represented an opportunity for personal advancement, even if the gains of this advancement would ultimately be shared with family members and other members of one's network. When individuals involved in medical aid spoke of Haitian health professionals' obligations to work in a particular location, it was always in reference to Haiti, and sometimes the specific locality the professional hailed from. I assume that Haitian health professionals themselves may not have felt an obligation to reciprocate to donor countries of aid because these countries are too wealthy to warrant a counter-gift, or because they do not conceive of aid from donor countries as constituting a gift, but rather contributing to Haiti's worsening social, political and economic climate.

In this chapter, I have attempted to describe and analyze the work of a small, secular, American medical organization in Haiti. In their choice not to carry out clinical interventions, Konbit Sante has relinquished one of the most powerful images of humanitarian activity in favor of a more administrative and systemic model of international medical intervention. Nevertheless, the group's members continue to face many of the same tensions and struggles as

[25] His departure from Haiti and his job with Konbit Sante were fairly abrupt: although he had maintained good relationships with his employers, tension emerged in the final months related to his expectations and hopes that Konbit Sante would continue to pay his salary even after his departure. In this way, Dr. Coulanges came to see Konbit Sante as a source of sustained, personal support, while the organization was unwilling or unable to modify their budget to pay for a former employee.

organizations working within more established and conventional models of medical aid. Most of the preceding discussion and analysis of Konbit Sante, its activities and the gift relations the group engenders and negotiates have been informed by the perspectives and data collected from the group's American staff and volunteers. In the following chapter, I will discuss Haitian medical staff's views of the international interventions that they encounter as part of their daily activities. I will also return to the theme of obligation, as young Haitian physicians debate their departures for the very countries that send them aid in various forms.

## Chapter 3 Haitian Health Professionals: Between a Fund and a Hard Place

On a warm spring evening in 2006, I sat with a Haitian physician in the dusty courtyard of a small rural hospital as he met with a dozen men and women who worked there as cleaners, janitors, and maintenance workers. The physician, a middle-aged man with a fatherly demeanor, had been hired by the American NGO who ran the hospital in partnership with the Haitian Ministry of Health to determine which staff members were in fact official employees of the establishment. His questions about how many years they had worked at the hospital and their specific functions were met with evasive answers and elaborate descriptions of economic difficulties, struggling households and dependent families. Unable to distinguish official from de facto employees, he exclaimed in frustration: "Look – everyone's got someone pushing in their back!" This image comes to life in Haiti during elections, school registrations and distributions of various kinds. When the stakes are high and the outcomes uncertain, people will stand crammed against each other, so that any movement at the back of the line is felt by those in the front, causing more stress and anxiety in an already tense situation. By using the pushing metaphor, the physician signaled to the hospital staff that, while he understood their financial obligations and the importance of their meager salaries in fulfilling them, he was also experiencing pressures, specifically from the foreign organization who had hired him to clarify the ambiguities and confusion regarding the hospital's staffing.

In this chapter, I analyze the situation of Haitian health professionals. In addition to their working conditions and claims on state and health infrastructures,

I analyze their interactions with and reflections on international medical aid. The Haitian health professionals that work closely with international interventions often find themselves in a situation that I describe as being between a fund and a hard place. The "fund" refers to the diverse resources (including money, equipment and supplies, medical services, and employment opportunities) that these professionals, through their involvement with international medical aid, are expected not only to disburse and channel to patients and others in need, but that also represent possibilities for their own professional and personal advancement. The "hard place" refers to the plight of the majority of Haitians, whose grueling lives are marked by poverty, hard labor, poor health and uncertain futures. The Haitian health professionals who are increasingly hired to implement, manage and disburse international medical aid are forced to negotiate a range of conflicting pressures, which often involve them in conflicts that are both in front of and behind them in the proverbial line.

Haitian health professionals' involvement with such aid is varied. Some are involved to a significant degree, such as clinical personnel hired by foreign NGOs, medical students and residents receiving training in foreign-sponsored medical school and residency programs, and the administrators and personnel of large international interventions. Lesser degrees of involvement may include fitting a patient for a pair of crutches donated by an international organization, getting a week off work because a foreign surgical team has taken over the operating room, or speculating about the origin of the foreigners taking pictures of infants in a hospital's neo-natal unit.

The context for the meeting I've described above is a revealing example of several forces at play in international medical aid in Haiti. The hospital, like many public health establishments throughout the country, had been under-staffed and under-resourced for years. With the death of its long-term medical director in 2002, it had fallen into severe disrepair, with no electricity, running water, or regular supply of pharmaceuticals or basic medical supplies. It was the only public health establishment for an estimated population of 70,000 people. In 2006, the leaders of an American-based NGO that had been operating a small clinic in the area approached the Haitian Ministry of Health with the goal of forming a partnership to revitalize the hospital. The Ministry would renovate the building and provide salaries for certain members of the hospital's staff, while the NGO would move its clinical activities from its dispensary to the hospital, while continuing to raise funds and seek out grants. The doctor who used the pushing metaphor was hired as a consultant by the NGO to help clarify the hospital's staffing and operations. He was recruited in part because of his experience working with another American NGO, and eventually left both organizations because he felt that his remuneration was insufficient.

Two trends have been particularly significant in shaping the work and lives of Haiti's health professionals in the latter half of the 20th century. The first has been the increase in international institutions, projects and campaigns that train and hire Haitian health workers for a wide range of positions, including administrators, physicians, nurses, laboratory and other technicians, and community health agents. These initiatives also hire an important number of

support and ancillary staff, such as cleaning and maintenance staff, drivers and others. This development is part of an increasing emphasis on the role of local human resources in health, visible in the World Health Organization's 2006 "World Health Report," which states that "At the heart of each and every health system, the workforce is central to advancing health." This report, like many others, identifies a lack in health care workers that has a negative impact on populations' health. Health care workers are described not only as responsible for carrying out technical procedures and dispensing health services, but, "are the personification of a system's core values – they heal and care for people, ease pain and suffering, prevent disease and mitigate risk – the human link that connects knowledge to health action (WHO, 2006)." Whereas earlier international health initiatives relied more on the work of expatriate health workers (and certain programs continue to do so), it is increasingly common for foreign organizations and agencies to not only hire but also train local health workers.

The second trend is the emigration of health workers from Haiti, particularly to the United States, the Dominican Republic, Canada and France. Health workers were prominent among the professionals who emigrated from Haiti in the 1960s (Fagen, 2009; Glick-Schiller and Fouron, 2001), and while the percentage of professionals among Haitian emigrants decreased significantly in subsequent decades (Portes and Grosfoguel, 1994: 58), a recent report by the World Bank estimated that tertiary-educated individuals in Haiti were emigrating at a rate of 83.6% in 2000 (World Bank, 2010). The same report cites a study

that found that over 35% percent of Haitian physicians emigrate annually (Bhargavan, Docquier, Moullan, 2011: 176).[26]

After a brief overview of Haitian health workers' historical contact with foreign medical interventions, I discuss the situation of a specific group of health workers: the medical residents at the HUJ. I addition to providing basic demographic information about the residents, I describe a strike they undertook in the fall of 2008 to highlight how medical professionals in Haiti interpret and respond to the challenges they face. I go on to describe some features of the residents' contact with international medical aid bodies. These features, as well as the residents' reflections on aid, illustrate how Haitian medical professionals view, critique, and work with and against international interventions. I then discuss the phenomena most often referred to as "brain drain," and the links between international medical aid and the emigration of Haitian health professionals. I close this chapter by discussing the theme of obligation and its multiple meanings in this context.

### 3.1 Historical Antecedents

Haitians have been providing health care in the context of foreign interventions, occupation, and domination for centuries. In tracing the historical roots of Haitian practitioners' involvement in international medical work, my goal

[26] While these two trends are not necessarily causally related, my informants drew explicit links between the two: Haitian health professionals often consider working for an international NGO to be a stepping stone for emigration, both in terms of the experience, language skills and contacts that are often gained through such work, as well as the possibility to amass the capital needed to leave Haiti, as NGOs generally pay higher salaries than those offered by the Haitian government.

is not to equate an 18th-century enslaved *hospitalière* with 21st-century nurse employed by a Canadian NGO. Such a comparison might serve as a provocative commentary on power relations and autonomy in the world of contemporary international aid, but also risks banalizing the extreme and horrific nature of chattel slavery in colonial Saint-Domingue, minimizing the significance and impact of the Haitian revolution, and suggesting equivalence between very different historical and socio-political contexts. Rather, my goal is to trace the occupational heritage of contemporary Haitian health workers and identify points of similarity or divergence with previous forms of healing on the island. Doing so brings into relief the fact that since the colonial era, medical practice in Saint-Domingue and Haiti has been closely intertwined with political and economic forces in other countries, particularly those originating in France and the United States.

Although hospitals in 18th-century Saint-Domingue included military hospitals, *hôtels Dieu* (for strictly medical care) and *hôpitaux généraux* (that served to confine beggars and other socially undesirable individuals), the predominant medical establishment during the French colonial period was the plantation hospital (Brodwin, 1996: 29-32). These establishments developed along with the rise of the sugar industry in the Caribbean, and while free and European doctors were sometimes summoned to treat certain ailments among slaves, plantation hospitals were principally staffed with slaves. These latter individuals found themselves in the convoluted position of being forced to provide care for fellow slaves whose forced labor enriched the owners of not only

the patients, but of the healers themselves. The "enslaved healers" of Saint Domingue included *hospitalières* (women in charge of plantation hospitals), *infirmières* (nurses or hospital aides), *accoucheuses* (midwives), herbalists and spiritual healers (Weaver, 2006: 42-58).[27]

One of the most contentious aspects of healers' work in colonial Saint Domingue was the practice of abortion or infanticide. Slave mothers and midwives were frequently suspected of using herbal treatments or other means to induce abortion, cause infantile tetanus, or kill newborns outright. This was done, the whites suspected, to keep infants from becoming slaves. Slave healers were also suspected of using their knowledge of herbal remedies to poison whites, and many empirically-identified cases of poisoning from historical accounts confirm that this was a well-founded fear. Other practices, such as providing hospitalization for malingering slaves and pilfering resources from plantation owners illustrate the complex array of choices and moral quandaries that were a part of daily life for enslaved healers during the colonial period (Weaver, 2006).

In the years following the revolution, plantation hospitals persisted, as did military hospitals and hospices operated by Catholic orders. Medical education for Haitians was limited, however, with only sporadic and short-lived efforts to train Haitian health workers in the early 19th-century. The national medical school began granting degrees in 1870, and in the decades that followed, hospitals

[27] Weaver also states that plantation medicine was extremely lucrative for European surgeons, and claims that many young surgeons travelled to Saint-Domingue from France in search of riches (46-47). This phenomenon may by a direct antecedent to the contemporary belief, widespread among Haitian physicians, that foreign and diaspora health workers are attracted to medical work in Haiti for pecuniary reasons.

founded by private citizens opened in major cities throughout Haiti (Brodwin, 1996: 44-45, 48). The HUJ is an example of an institution that was established during this period.

The U.S. Marine occupation of Haiti, which lasted from 1915 to 1934, radically transformed medical practice throughout the country. While the occupation is generally viewed with a critical eye by contemporary scholars, who decry its financial exploitation, centralization, and brutality, it is also credited with building hospitals throughout the country, developing the bureaucratic and administrative structures for a public health system, and introducing nursing to Haiti. Dr. Ary Bordes, a preeminent historian of medicine in Haiti, has written a detailed account of medicine and public health during the American occupation (Bordes, 1992). He traces the early medical efforts by the occupying forces, which centered first on medical services for American soldiers and the newly created *Gendarmerie d'Haïti* ("Haitian Constabulary"), and the creation of the *Service nationale d'hygiène publique* ("Public Health Service of Haiti"), which would eventually become the country's Ministry of Health. This Service focused on public hygiene and sanitation, the treatment and control of infectious diseases, and the development of health facilities. Bordes (1992, 95-96) argues that the Service's focus on urban sanitation and health also entailed a neglect of rural Haitians, which during the American occupation represented 95% of the population.

In the early twentieth century, there were fewer than 100 physicians in Haiti, most of them working in Port-au-Prince. As a reflection of the Francophile

intellectual and social trends of the era among the Haitian middle and upper class (Valdman, 1984), many had completed basic or supplementary medical studies in France, but few had studied in the United States, a destination of much lesser appeal (Bordes, 1992: 34). In the twentieth century, however, Cueto describes the "increasing process of 'Americanization' and a corresponding decline of European influence, especially French influence, in Latin American medicine and medical sciences (Cueto, 1994: xv). Describing the Rockefeller Foundation's activities in Latin America, Cueto writes,

> "Shortly after their creation in the early twentieth century, American philanthropies began to export to less-developed countries institutional models for the organization of knowledge, under the assumption that the giver knew what was good for the receiver. This assumption reflected the institutions' perceptions of isolated elements of foreign cultures, and their comparisons of these perceptions with social, cultural, and scientific developments in the United States. […] There were constant references to the role that German-trained U.S. students played in the modernization of medical education and research in the United States. Foundation officers became sincerely convinced that the RF would play the same role in Latin American science and medicine that Germany had played in the reorganization of U.S. science. RF officials proceeded from a main assumption—that the most-advanced Latin American institutions and societies could replicate the development of their counterparts in the United States (Cueto, 1994b: 1, 13-14)."

In his subsequent volume tracing the history of medicine in Haiti following the American occupation, Bordes frames his findings in a discussion of Haitian society more broadly, arguing that the hierarchies and divisions that marked the colonial period remained in large part intact during the middle of the twentieth-century, but was also marked by the emergence of a black middle class in the 1940s, a group which he claimed would join the mulatto elite in oppressing the rural masses (Bordes, 1997: 24). He also traces the earliest permanent migrations of Haitian health professionals to not only the metropolitan areas in the northeastern United States and Canada, but also in lesser numbers to Liberia and

Venezuela. (This flow would increase in the 1960s as health professionals fled the repressive Duvalier dictatorship.)

While limited in comparison with the present-day situation, the scope and diversity of international interventions increased during the middle of the 20th century. Bordes traces the implementation of a number of projects by different international actors: the construction of clinics, hospitals, latrines, and other infrastructure projects (implemented by the Rockefeller-funded MSA American Sanitary Mission); yaws eradication and health worker training (by the Inter-American Cooperation Service of Public Health, the MSA's successor); and insect control, research, training and laboratory support (by the Pan-American Health Bureau). He also describes the activities of various UN agencies (UNESCO, UNICEF, FAO, WHO, etc) and the early implantation of NGOs such as CARE. Bordes identifies yaws eradication as the greatest medical success in the country during this period, and the most famous medical professional involved in this campaign was none other than future dictator François "Papa Doc" Duvalier.[28]

Other than the emigration of medical professionals, little has been written about health and international intervention during the Duvalier dictatorship. In more general terms, scholars have addressed the suspension and renewal of American aid to the Haitian government under the Kennedy and Nixon

[28] Bordes gives a bleak portrayal of the subsequent period: "In the decades to come, the role of international assistance would increase and the country would become increasingly dependent on foreign aid, without ever being able to resolve its health problems. Our leaders should be aware of the role, reach, limits and use of external assistance if they wish to avoid being disillusioned by the promises of international diplomacy and the mirages of international organizations (Bordes, 1997: 214-215.)

administrations, respectively, and the increasing reliance on NGOs to support foreign programs in health, agriculture, and education during this period (Buss, 2008: 70-71). This period also saw an increase in French-Canadian Catholic missionaries in Haiti, many of whom were involved in health interventions through hospitals, clinics and dispensaries run by their religious orders. While this topic has not been extensively researched by historians, Sanders (2010) suggests that relationships with between Canadian missionaries and Haitians were extremely hierarchical, a tendency which shifted as the missionaries aged, creating a need to rely increasingly on younger Haitian clergy and medical professionals.

### 3.2 Haitian Healthcare Workers Today

Demographic information in Haiti, including data about occupation, is extremely difficult to obtain. Censuses are conducted only sporadically, and many demographic estimates are based on imprecise and dated calculations. The population of Cap-Haïtien, for example, is estimated to be anywhere from 100,000 (Oxfam, 2010) to 800,000 (FCO, 2009). Estimates of the number of health care workers have largely based on conjecture or simply absent. In 2007, the *Projet d'Appui au renforcement des capacités en gestion de la santé en Haïti* (PARC), a project based at the University of Montreal's International Health Unit, partnered with the Haitian Ministry of Health to conduct a nation-wide census of health-care workers. In addition to collecting basic demographic information, the census also recorded the occupational specialties and type of employer of each

health professional. In addition, the census collected information about medical education and training in Haiti, and about the emigration of recent graduates. The scope and detail of this census, which relied on a team of over sixty individuals, are impressive, and provide valuable information on the human resources and staffing of health establishments in Haiti. The motivation behind the census was "equip [MSPP] to develop and put into place policies for human resources that are adapted to the needs of the health system (Dubois, 5)." The census offers one of the only comprehensive and reliable sources of data on Haitian healthcare workers.

The census reports that there were 2.61 health workers per 1000 individuals, one of the lowest rates in the world. It also states that 40% of the 24,278 healthcare workers were support, administrative and logistics staff, a higher percentage than in most other countries. Only 31% of healthcare workers had university-level training, and only 27% had a professional status that qualified them to provide services autonomously (physician, nurse, midwife, dentist, pharmacist, etc). In terms of ratios in the professional categories, approximately 10% of health workers were physicians, who were slightly outnumbered by nurses and midwives (13%). Clinical aides and auxiliary nurses represented 27% of all health workers.

According to the census, Haiti's ratio of physicians and nurses is only .59 per 1000 individuals, which is far below the WHO's recommended rate of 2.5, the rate the organization claims is needed to provide basic vaccines for 80% of the population and safe childbirth for 80% of pregnant women (Dubois, 11). The

PARC census also found that public institutions have the highest rate of support, logistical and administrative staff, a rate of 42% compared to a rate of 28% in private establishments. Private establishments employ a much higher rate of technicians than public establishments, owing in part to the prevalence of private laboratories and the paucity of laboratory resources in most public clinics and hospitals.

Other findings include that 66% of healthcare workers are under the age of 45, and nearly half of them (46%) work in Port-au-Prince and its surrounding areas. The census found that a minority of health care workers (18%) worked in primary care facilities such as dispensaries and health centers, which are often the only medical establishments that are easily accessible for rural populations. Almost half of health care workers are employed in hospitals (generally located in urban areas), private clinics, and MSPP offices, and, in such settings, are not accessible for impoverished and/or rural patients.

Contemporary Haitian healthcare professionals have not been the subject of significant attention by social scientists. When mentioned by medical anthropologists, they often appear as secondary figures, either as obstacles to satisfactory patient care, or less frequently, as heroic supporters of medicine for all. In Maternowska's (2006) analysis of a family planning clinic in the Port-au-Prince slum of Cité Soleil, physicians represent "a small slice of Haiti's privileged class." During their extremely brief consultations with patients, they bark orders, dismiss medical and economic concerns, and are disconnected from the rest of the clinic staff. (Maternowska, 75; 95: 2006). They are there to provide technical

skills only, and work at the clinic "only for the extra cash (ibid)." Although Maternowska found that doctors and nurses analyze and understand the macro-level forces that shape fertility and contraception use in Haiti, "… the understanding of macro forces was distinctly removed from the micro situation in the clinic - or the community - and their analyses did not appear to inform their treatment or discussion of clients. Indeed, their analyses confirmed an enormous gap between insight and practice (96)." The author suggests that these tensions are systemic rather than individuals' failings by describing the clinic's director:

> "When he formerly worked as a clinician, he would often joke with the clients and engage in their lives. Frequently he would go out of his way to help someone in need. He was a *dòk* [doctor] that everyone loved. As the son of two farmers, he was one of the lucky (and few) brilliant students who actually made it into Haiti's state-managed medical school without ties to the upper classes. Years of working at this clinic and dealing with the rigorous demands of international agencies had slowly transformed this man from a humble, client-devoted doctor to a hard, urban bureaucrat who directed the clinic (Maternowska, 94)."

While Maternowska acknowledges some of the institutional and structural constraints that health professionals face (resource scarcity, little credit or recognition for their efforts, boring and repetitive work), her account focuses on the ways they perpetuate and reinforce hierarchies and inequalities in Haitian society, to the detriment of their impoverished patients.

Brodwin's (1996) description of nurses is similar – he describes a "code of deference," or "the mutual expectations and taken-for-granted rules which pattern unfolding activities," including provider-patient interactions in a rural Haitian dispensary. Nurses and nurse auxiliaries publicly criticize and shame patients in the dispensary's waiting room, using their cases as examples for other patients and as opportunities to deliver instructions on proper nutrition, the care of children, and other matters. Brodwin compares these interactions to those which

take place in schools and courthouses: "social relations that are formal, authoritarian, and partially inscrutable to the petitioners below (67)." In rural areas such as the village where Brodwin conducted his research, physicians often do not have a permanent presence, but rather carry out rotations as part of their mandatory year of social service upon completing medical school, or as part of an arrangement to attend to patients in several clinics in a geographic area.

My findings complicate these analyses somewhat. First of all, it became apparent during my research with the medical residents at HUJ that they do not represent Haiti's elite in the ways that physicians of previous generations may have. Although they often do reproduce social hierarchies in their interactions with patients, they do so from a middle-class position that, while sparing them the plight of Haiti's impoverished masses, is subject to significant instability and insecurity about its future prospects. This is particularly true for younger physicians, such as the medical residents at the HUJ.

### 3.3 The Residents at the HUJ

During my research, there were fifty-four medical residents at the hospital, pursuing either three-year (pediatrics, obstetrics/gynecology, internal medicine, urology, family practice) or four-year (surgery, orthopedics, and anesthesiology) specializations. I conducted in-depth interviews with fifty-two of the residents, using an open-ended questionnaire that focused on international interventions and the practice of medicine at the HUJ and in Haiti more broadly.[29] I chose to

[29] Two residents refused to be interviewed: one who repeatedly missed appointments I set with him, and another who simply told me that she did not wish to answer any of my questions. As

interview the medical residents for a number of reasons. Out of all of the hospital's medical staff, the residents spent the most time at the establishment. At any given moment, approximately thirty-five residents lived on the hospital's campus. The remainder lived with relatives or rented rooms in Cap-Haïtien, and others left periodically on rotations to other hospitals in Haiti. As residents were prohibited from seeing patients in private practice, they devoted all of their efforts to their hospital work and to their studies. In this way, they were not only intimately familiar with the hospital's services and operation, but also became a constant presence during my research, much more familiar than the attending physicians. Nurses were fairly consistent in attending their shifts, but these shifts were often quite short, and they, like the attending physicians, also worked in private practice and other sectors such as commerce and teaching, which reduced their presence and availability at the HUJ.

Medical education in Haiti follows a European model, in which students enter medical school after completing high school and taking an entrance exam. During the time of my research, there were four government-recognized medical schools in Haitian universities. These include the Université d'État d'Haïti, the state university with a graduating class of about one hundred medical students annually; Université Notre-Dame d'Haïti and Université Quisqueya, private universities with graduating classes of approximately fifty students each; and Université Lumière, a much smaller university with graduating class of a dozen medical students.

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many of the residents themselves had to conduct qualitative interviews as part of their own required research projects, most were already familiar with the interview process.

With a single exception, the residents at the HUJ had all studied at Université Notre-Dame d'Haïti or Université Quisqueya, the two major private universities.[30] Resident positions at the capital's main public hospital, the Hôpital de l'Université d'État d'Haïti are "reserved" for graduates of the state university, an arrangement that greatly displeased many of the residents, who would rather have stayed in Port-au-Prince. (The residents complained that to enter the state university's medical school, one had to have personal contacts. Not only was the state university significantly less expensive than the private universities, but the quality of education it offers is reputed to be higher.)

In looking at basic demographic indicators for the medical residents at the HUJ, several patterns emerged. About one half of the residents were from Port-au-Prince, one quarter from Cap-Haïtien and its surrounding areas, and the remainder from other parts of Haiti, generally from cities and larger villages. Thirty-one of the residents were women, twenty-three were men, and they ranged in age from twenty-seven to thirty-six. The majority had been to private Catholic schools for their primary and secondary education[31]. In asking about their parents' professions, I was surprised to find that only four had a parent who was a physician and five had a parent who was a nurse. Instead, some of the residents' parents were low-level professionals, (primary school teachers, secretaries, low-level government workers), while the majority worked in trades: commerce, food service, tailoring, and other occupations. I had assumed that physicians in Haiti

[30] I was unable to determine why a graduate of the HUEH came to a residency at the HUJ: the resident in question would not answer my direct questions about the situation.
[31] I commonly heard from both Catholics and non-Catholics that Catholic schools provided a higher quality of education than public schools or other church-affiliated schools.

came from relatively elite and wealthy backgrounds, as may have been the case historically. I recall my surprise at meeting a woman who I assumed (because of her dress, demeanor, and speech) to be a resident's hired domestic employee, when in fact she was the physician's mother, and her primary occupation was small-scale commerce. While I heard both state university-trained Haitian physicians and international healthcare workers claim that the graduates of private universities came from wealthier families who could afford the university's annual fees (approximately 700 USD), I am unable to verify this claim. From my interviews, however, I learned that nearly every resident at the HUJ had close relatives living abroad, including parents, aunts, uncles and siblings. Given the importance of overseas remittances by migrants to household incomes in Haiti, it is plausible that these residents' access to higher education was facilitated by contributions from relatives abroad. However, these contributions may not have been sufficient to enable the residents' own migration and education abroad. According to both my informants and my own observations, the children of Haiti's bourgeois elite are increasingly educated abroad, but rely on their families' wealth to do so. Based on their parents' occupations, their educational backgrounds, speech and demeanor and, and their own self-identification, I would identify the majority of the HUJ's residents as belonging to Haiti's small middle class.

The residents also occupy an interstitial position in terms of hierarchies within the HUJ. As physicians, they have greater prestige and authority than most of the hospital's staff, including nurses, auxiliaries, interns, and almost all non-

medical personnel. However, as the youngest physicians, and because of the relative brevity of their presence at the HUJ, they have little sway or decision-making power when compared to the attending physicians or senior members of the hospital's administration. Patients often refer to them as "*ti doktè,"* or "little doctor," a term which can be either disparaging or affectionate. Because many are from other parts of Haiti and new to the hospital and Cap-Haïtien, they do not have the contacts and social capital long-term personnel might be able to draw on. In addition, residents are not allowed to have other employment, and since most comply with this regulation, their income is limited (I knew of only two residents who had outside work, teaching an occasional science classes at a local high school). These factors leave them in a somewhat precarious state: while certainly not confronted with the extreme struggles for survival that are faced by Haiti's impoverished masses, the residents often described their time at the HUJ as being particularly arduous, in terms of living and working conditions, workload, and pressure to fulfill a range of debts and obligations, particularly to their families and extended kin networks. Their frustration with the hospital's administration, the Ministry of Health and the Haitian state in general was exacerbated by long delays in salary disbursement, and in the fall of 2008, culminated in a strike.

**The Residents' Strike**

Compared to the standard of living of the majority of Haitians, the residents at the HUJ led a fairly comfortable existence. Approximately thirty had a room on the second floor of a large building whose ground floor was intended

for private rooms for patients who could pay extra fees for this luxury (*salles privées*). Although the residents' rooms were fairly small, they had been recently refurbished after a fire destroyed the building in 2003, and each room had a single bed, a tile floor, and high ceilings. Communal bathrooms gave the residence the feeling of a college dormitory, and residents occasionally socialized in the rooms of their friends, although most of the time doors were shut, with residents either sleeping or working on the wards. Three small areas at the angle and each extremity of the L-shaped building were used for drying clothes, eating meals, and socializing.

This relatively comfortable appearance belied some major concerns that made residency at the HUJ a period of stress for young physicians. Foremost among these were those related to salaries. The Ministry of Health allotted a stipend of approximately 200 USD per month per resident, a sum nearly seven times as much as the average per capita income in Haiti, but with rising food and fuel costs, this amount was described as unreasonably low by all residents, particularly for those with children or other relatives to support, and those who had accumulated debt during their studies. Exacerbating this problem was the fact that stipend payments were often late, and residents regularly went for over six months without being paid. While they remained confident that the payments would arrive (and as I observed, they eventually did), working for months without income was chief among the residents' complaints.

The residents were also unsatisfied with their housing. While the building mentioned above housed thirty residents, and some found lodging with relatives

in the city, the remainder were housed in two other buildings, one of which was equivalent to the main residence in terms of comfort and amenities, and one much inferior. The "*Kay Rat"* (Rat House), as it was called, was above the patient wings in internal medicine, and with its rotting wood floors and particle-board partition walls, was indeed a haven for rats and other vermin. In addition, the residents' room was directly under the building's corrugated tin roof, which made their quarters unbearably hot for much of the year. All of the residences were affected by frequent water and electricity shortages, and this was also a source of aggravation for the young physicians. Fetching water, whether for bathing, cooking or drinking, is considered a particularly lowly task in Haiti, and is generally assigned to children or domestic servants. Since nearly all the residents lived away from their families and domestic workers, they would pay hospital employees to carry their water for them, or because of financial constraints, haul it themselves, a point of particular contention among the male residents. Electricity was used to power laptop computers, fans for ventilation, radios, and in several cases, television. While power outages were considered inconvenient and aggravating, all of the residents seemed accustomed to them from before their arrival at the hospital, and did not create as much anger and frustration as the water shortages.

Meals were also a key concern for the medical residents. While none of the young physicians suffered from food scarcity or insecurity in ways that resembled that of their poorer compatriots, access to regular, nutritious meals remained a challenge. Two couples of married residents who lived in the

residence with their children each came to the hospital with two domestic workers who cooked in addition to doing laundry and providing child care. A few other residents arranged with their colleagues (the domestics' employers) to have portions of food prepared for them as well. Others ate at nearby restaurants or food stands, while most made arrangements through a local caterer who had daily meals delivered. The caterer was understanding enough to accept deferred payment for meals, given the long delays in the residents' paychecks. The residents spoke about their discomfort of living on credit, a common practice among poorer Haitians that generated a great deal of stress and anxiety.

After months of not being paid, ongoing water shortages in the residences, and what they described as intolerable working conditions, the residents decided to go on strike. This decision was reached after a series of heated meetings in the residents' dining area. The extensive discussions were attended by nearly all of the residents, and characterized by lively debates and occasional shouting, as well as outbursts of laughter. Charismatic residents, particularly those who were gifted in speaking and organizing rhetorical points, emerged as de facto spokespeople, while others took a more passive role in the negotiations, or simply stopped attending the meetings.

The strike was a moment where the residents' claims for better working conditions and a what they considered to be a minimum standard of living for healthcare professionals were articulated through physical protest and impassioned discourse. To launch the strike, the residents held a press conference at the hospital. In addition to reading a statement which highlighted the factors

motivating their strike, they also projected photographs intended to garner the journalists' sympathy. These included images of a male resident carrying water up the stairs to his dormitory, the decrepit bathrooms of the residences, and a resident performing a procedure on a patient at night by the light of a colleague's cell phone. The journalists did indeed seem sympathetic to the residents' claims. The residents' claims and complaints dovetailed with those of the general population in the identification both of the primary problem and its cause: a lack of resources that stemmed from an absent or dysfunctional state and the country's irresponsible and corrupt leaders.

At the beginning of the strike, the residents used a dramatic strategy to disrupt activities in the hospital's administration. Approximately twenty of them entered main offices' reception area and, pounding buckets with sticks, beating the wooden benches with their hands, and scraping empty cans of infant formula on the cement floor, made such a deafening din that it was impossible to concentrate, much less accomplish any work or hold meetings. Some of the lower-level administrative staff who sympathized with the residents seemed to enjoy the rhythmic protest, and one of the residents danced in a ring of noisemaking protesters in the style of Haitian *rara* band leaders. In their protest, the residents drew on several dimensions of Haitian performative protest, including call and response chanting (McAlister, 2002). A leader yelled, "*Bourik la…*" (The donkey…) to which the others responded, "…*bouke!"* (…is exhausted!) The image of the donkey, the Haitian work animal *par excellence,* was often used by the residents to describe their plight. Another chant involved a

particularly unpopular administrator, who had expressed a callous insensitivity to the residents' requests for water by telling that the ocean was just down the street. They nicknamed this administrator "*Mannken"* or "Model" because of his stylish and expensive wardrobe, and the chant described his incapacity and unwillingness to resolve basic problems. Even residents who were normally reserved and quiet enthusiastically joined in chanting and pounding noisily on pots and furniture.[32]

The hospital administration's reaction to the strike was somewhat ambivalent, but mostly supportive of the residents. While they did not take any actions that explicitly supported the strike, the HUJ's directors told me that it was understandable that such actions take place, given the long delays in paychecks. However, they were unable to openly support the strike as doing so would have compromised their loyalty to their superiors at the Ministry of Health. Many of the hospital's staff physicians also supported the residents in their actions, but some were put off by the residents' use of a common Haitian proverb: "*Bourik travay, chwal galonnen"* (The donkey works, the horse is decorated.) Certain staff doctors did not appreciate this tacit critique of their absenteeism, and asked the residents to refrain from using this proverb in their protest. Nevertheless, the image of the donkey persisted, both in protest chants, as well as posters that the residents made to hold during demonstrations.

The strike lasted for just over a month. During this period, the residents employed a variety of protest tactics, including sitting on benches in front of the

[32] The residents' protest was reminiscent of *bat tenèb,* or "beating the darkness," a form of protest in poor urban areas that was used during coup d'états and other periods of political repression (Maternowska, 2006: 7). During bat tenèb, participants beat metal items such as pots, pans, and metal posts to create a din of collective protest.

administrative offices (so that none of the staff could enter the building), standing and sitting in protest in front of the hospital gates so that no vehicles could enter the hospital grounds (during the seated protests, some of the residents played Monopoly, the only time I have seen this game played in Haiti), and continued radio interviews with local and national journalists. Residents frequently mentioned that it was important to gain the local population's sympathy: families of patients unable to access care at the hospital would be particularly opposed to the strike and possibly aggressive towards the residents, but the latter hoped that their claims for remuneration and decent working conditions would earn empathy and support. Protest signs to achieve this goals included those which read, "Even if you see that I'm well dressed, I'm living on credit," "A stethoscope and a white

coat aren't worth anything in the market," and "*Klowòks* is hard for everybody."[33]


Figure 3.1 Medical residents protest at the gates of the HUJ. Their signs (starting at the top and moving clockwise) read: "The donkey is f…ing exhausted," "*Klowòks* is hard for everyone," "The donkey works, the horse is decorated," "9 months aren't 9 days," "Respect for all professionals, especially health professionals." The sign at the far righ shows a donkey with a white coat, stethoscopre, and medical bag being pointed at by accusatory fingers. Photo by the author.

The residents continued to meet as a group throughout the strike, and many of their discussions centered on cases in which they should make exceptions and provide care. While all of the residents agreed that care should not be withheld in cases where patients lives' were at risk, determining this criteria proved to be far from straightforward, and residents offered different interpretations of what they considered to be life-threatening conditions. Some

[33] The expression "*klowòks*" became popular throughout Haiti in the spring of 2008, when rising food prices led to hunger and protests throughout the country. The term comes from the commercial brand of bleach Clorox, and referred to the burning sensation in the belly caused by extreme hunger.

residents were not supportive of the strike at all, feeling that their professional status obligated them to provide care despite the delays in remuneration. Others were concerned that the interruption in their work would lead to an extension of their residency and delay its completion. (This proved to be a valid concern, when many of the department heads did in fact extend the length of residencies to compensate for the work that was "lost" during the strike.) For the most part, however, the residents were united in their strike for the five weeks of it duration. It ended when the Ministry of Health sent checks to residents that covered six out of ten months of back pay. During the strike, medical activities at the hospital decreased significantly. Nurses complained to me that they had to work longer hours to compensate, but I did not notice any increase in the presence of attending physicians during the strike.

The strike led to a major disruption in the hospital's services and led to the very visible and public expression of residents' frustration, dissatisfaction and claims on the hospital's administration and Haitian state. Rather than responding to an exception or unusual situation, however, the residents reacted to a series of chronic deficiencies and challenges that characterized their work before and after the strike, and that are widespread in public health establishments throughout Haiti. While the strike itself did not directly involve international actors or agencies, it concerned many of the problems and shortcomings associated with government-run health establishments in Haiti, and that often compel Haitian health care workers to seek employment with foreign agencies and governments.

In the following section, I discuss the residents' reflections on international interventions at the HUJ and in Haiti more broadly.

**Reflections on Foreign Aid**

When I asked the residents about their involvement with international aid, they initially minimized their contacts and relationships with the latter. Oftentimes, they situated themselves as mere observers or witnesses: "I see them come through the hospital and drop things off, but I've never talked with them or asked where they're from." One whose program was sponsored and structured by a foreign group told me, "We're not really involved with them, sometimes when they give trainings… what else… I carry out what they ask for in the unit, we give care to people with HIV/AIDS, but direct ties, I can't say that we have any." Many stressed that they had no contact whatsoever with foreign aid in any form, but when I prompted them by naming specific groups or interventions, they acknowledged their presence and activities in their services. While not all residents are in direct contact with foreign aid workers on a daily basis (although many are), all are involved in some way with international interventions in their work. Involvement may include: prescribing or dispensing donated medications and goods, using donated equipment or working in donated facilities, implementing programs designed by international agencies, working alongside foreign medical staff and attending foreign-sponsored or foreign-led trainings both in Haiti and abroad.

There are two factors that I believe explain why Haitian healthcare

workers to minimize their contact with international interventions. The first is that many of these interventions are so pervasive throughout medical establishments in Haiti that they are not considered to be a form of foreign aid. All of the vaccines that I saw at the hospital, for example, had been donated by international agencies and governments, yet were never named by informants as a form of foreign intervention. Donated medications and equipment, buildings sponsored by foreign funds, paperwork and forms designed and printed by international agencies and NGOs; these all formed a part of the residents' daily work environment, and while they would recognize them as international in origin if I asked about them specifically, they rarely volunteered them when asked in more general terms. This even applied to foreign aid workers: after a resident would tell me that they had no contact with any form of international medical aid, I would ask if they had any Cubans working in their service, to which they would often respond by exclaiming, "Oh, yes, we do! I forgot about the Cubans!"

The second factor that may explain Haitian healthcare workers' tendency to minimize or downplay the presence of international interventions in their places of work has to do with a more widespread phenomenon I observed among people in Haiti: that of being discrete about and in some cases disparaging of available resources. As I will discuss in the following chapter, there are pragmatic reasons that make it advantageous for the recipients of aid to deny the existence or minimize the importance of existing sources of support, specifically because doing so may increase the chances of obtaining additional resources. In addition, it is not uncommon to hear people in Haiti make totalizing

pronouncements to describe a predicament they consider particularly dire: "This isn't a hospital! A hospital wouldn't run like this, it wouldn't be in this condition!"; "We don't have a government in Haiti, we don't have leaders."; "There's nothing good left in Haiti." Claiming that there were no international interventions or support in their respective departments would strengthen the residents' commonly-repeated claim that the HUJ had no redeeming qualities.

While nearly all of the residents initially minimized their own contact with international medical aid, all acknowledged that such aid was present in the hospital, and when asked to elaborate, almost all began by describing the work of Konbit Sante (with the exception of the residents in the family practice training program sponsored by the Florida-based university, who spoke first of that program). As mentioned in the previous chapter, descriptions of Konbit Sante and its activities often focused on the group's provision of materials and supplies. Other foreign interventions that were commonly named included those which involved a variety of the hospital's departments, such as PEPFAR's provision of HIV treatments and services, or the visiting teams of American and Dominican orthopedists whose week-long stays in the HUJ's main operating room affected all of the hospital's surgical activities. Finally, many residents mentioned programs that involved opportunities for them to travel abroad for training: Konbit Sante facilitated travel to Maine for several surgery residents in the summer of 2008, and a French university offered similar opportunities for anesthesia and internal medicine residents. As these interventions were not specifically directed at residents, but also represented extremely desirable

opportunities for them, it is not surprising that they were mentioned by many of my informants. Other initiatives, such as smaller projects that affected a single service, were rarely mentioned by my informants.

In addition to contact with international interventions through their work at the hospital, nearly all of the residents had spent some time abroad, not only for trainings or students exchanges, but also to visit relatives and friends, mostly in North America. During my research, two residents traveled to the United States in the later stages of their pregnancies, giving birth to babies who qualified for American citizenship and strengthening the transnational ties that offered the promise of future emigration. Residents had also had contact with international interventions during medical school (approximately one third of them had participated in a month-long internship at a French medical school), during their year of social service in health establishments (mostly public hospitals and clinics, but these often had international interventions present in them), or during residency itself, when residents in family practice, pediatrics, and surgery had month-long rotations in various NGO-run hospitals throughout the country. Their reflections on these latter experiences are particularly telling.

I asked the residents to compare their experiences working in health establishments operated by international NGOs and the HUJ. All who were in a position to make this comparison agreed that the work environments were very different, and they focused on two main points. The first was that in foreign-run, private hospitals, materials and resources were available when needed, both in terms of specialized equipment and materials, and in terms of basic resources for

patients. Residents remarked that patients received care and basic services even if they didn't have the means to pay, whereas this was not the case at the HUJ. The second point was related to management: most of my informants who had worked in NGO-run hospitals claimed that the management was better than in the public system. As on resident told me, "In the state system, you often get the impression that the medical staff often do what whatever they want. But in NGO hospitals, one has to do exactly what they ask of you, from the intake to discharge." While others emphasized that NGO-run hospitals have their own problems and shortcomings (one resident told me that she had not been impressed by any of the four NGO hospitals she had worked at), the consensus was that health care facilities operated by foreign NGOs offered better services for patients and better working conditions for staff than did public facilities. Despite this relatively positive assessment, the residents offered an ambivalent analysis when asked to describe the motivations of foreigners carrying out medical interventions in Haiti.

**Reading Motivations**

When I asked the residents what they thought motivated foreigners to come carry out medical interventions in Haiti, most respondents began by stating that they were unsure. A few, particularly those with whom I had less rapport or were less comfortable with being interviewed, refused to even conjecture, simply saying that they didn't and couldn't know. The majority, however, continued by telling me that they thought that there were two types of people who came to Haiti to do medical work. The first were described in terms such as "people who really

want to help us"; "those who see how many problems we have and are motivated by the suffering they see"; "people who come in come with good will and want things to change." These motivations were described in matter-of-fact terms: the residents did not elaborate on their responses, speculate on the origins of these motivations, or associate them with a specific nationality or religion.

The second group described by the residents consisted of people who came to Haiti for other reasons. Foremost among these was personal financial gain. Salaries paid to Haitians by international bodies, particularly NGOs, tend to be significantly higher than those paid by the government of Haiti. Specifically in the health field, work with international employers is considered to be particularly lucrative – it is not surprising, therefore, that the residents associated work with international agencies with lucrative pay. In addition, international aid workers often have access to luxuries such as private vehicles, elegant hotels, and exclusive social spaces, none of which are within the reach of the majority of people in Haiti, not even for many healthcare workers who earn relatively high incomes. As one resident told me *"Ils viennent pour faire leur beurre* (literally: "They come to make their butter"). None of the residents I spoke with claimed that foreign aid workers' activities in Haiti should not be remunerated – their objections centered more on the discrepancy between claims of assisting others while acting principally out of self-interest. There were also some who observed that foreigners' salaries were disproportionately high when compared with the wages earned by Haitian health professionals.

Another motivation cited by several residents was foreigners' desire to see exotic or unusual pathologies. Those who spoke of this issue generally told me of a first-hand encounter working with a foreigner or group of foreigners who became visibly excited when seeing cases such as malaria or dengue. In the words of one resident: "There are some who are happy to see cases that they don't see in their own country. I was at a hospital where we were examining a patient who had an intestinal perforation caused by typhus. The foreigner next to me said, 'Wow! It's like in the books!'" Many of the international medical aid volunteers and workers who travel to Haiti usually work in relatively affluent communities, where infectious diseases and other ailments linked to extreme poverty may be relatively rare, or where pathologies and injuries will be treated at an earlier state, rather than developing into more serious and dramatic conditions as they often do in Haiti. In addition, many are either older professionals who seldom confront unfamiliar pathologies in their own practices, or younger students and clinicians who are particularly enthusiastic about opportunities to encounter a wide range of pathologies. As trainees themselves, the Haitian medical residents I interviewed could relate to the pedagogical potential offered by exotic pathologies.

Other motivations for foreigners to practice medicine in Haiti that were named by the residents included the possibility of trying out experimental therapies ("They come to do experiments. Where they come from, there are so many regulations, there are things they can't do there"), to help control infectious diseases that could threaten their own countries, or simply "to be seen" doing

good works. In addition to suspecting that not all foreigners who came to carry out medical interventions were motivated by altruism, a similar ambivalence applied to material donations. Residents frequently complained that broken, useless, and expired equipment and supplies were sent to Haiti because the sending country had no use for them. Several suggested that it might be easier to send the refuse to Haiti rather than dispose of it domestically, while others commented that donors could obtain tax rebates for doing the former.

Even those residents who did not name specific unsavory motivations commented that they doubted that all foreign aid in Haiti was motivated by altruism, both in the case of medical aid, and in terms of international interventions more generally. The evidence supporting these doubts was clear and simple: worsening conditions throughout the country. As one resident explained: "It's as though they're not really helping, because the problems are still there. We have plenty of organizations that are 'helping' in this or that area, but we get the impression that the organizations make it so that the problems stay, so that they can stay and profit." In addition to the sheer number of international organizations and agencies active throughout Haiti, residents often mentioned that they were constantly hearing news reports about large sums of money that had been pledged or delivered by international bodies. Why, they wondered, are conditions getting worse if so many resources are purportedly directed toward improving them? These worsening conditions, even before the catastrophic events of 2010, were prime factors in motivating their intent to go, in words of one resident, "where they need me."

### 3.4 Emigration and "Brain Drain"

Emigration is a constant theme in the lives of Haitian professionals. While a desire to travel abroad is commonly expressed by young Haitians of all socio-economic classes, young professionals usually have many relatives and colleagues who have already migrated, and most seem to be actively exploring avenues for migration. Out of the fifty-two residents I interviewed, only two told me that they did not intend to leave Haiti to pursue careers abroad. The majority told me that that they planned to go to the United States (several named Canada and France as desirable destinations) and many were preparing to take the USMLE exams that would permit them to enter an American residency program. Some planned to work in nursing or other health-related professions, and a few planned to leave the medical domain entirely. Based on the experiences of family members and colleagues, many anticipated that emigration could involve a decline in their professional status. The residents often heard and repeated anecdotes of doctors, nurses, lawyers and teachers who left Haiti and, due to factors ranging from racism and xenophobia to the challenges of a foreign language and adapting to a new society, became taxi drivers, maids, and manual laborers in North America. Aware of these risks and encouraged by stories of spectacular successes and accomplishments, the residents remained committed to their projects for better lives *lot bò dlo*, on the other side of the water.

The term "brain drain" was first used in the 1960s by scholars examining the movement of educated and skilled professionals from Western Europe to the

United States (Grubel and Scott, 1977:3-4). For many years, the term was accepted at face value: the departure of scientists, engineers, health professionals, and brilliant students represented a loss for the sending country, particularly those lacking in human resources and basic infrastructure. In recent years, however, the concept has been critiqued, and new terms have been introduced to add nuance to analyses of migration. "Brain gain" was coined to describe the benefits for sending countries that often accompany the emigration of skilled professionals, including remittances, return migration, and diaspora networks.[34] "Brain circulation" highlights the continual movement of migration professionals, who, rather than migrating a single time from a poorer country to a wealthier one, are involved in lifelong movements and exchanges across national borders (Patterson, 2007). "Brain waste" is used to describe both the inability of professionals to reap the benefits commensurate with their education and talent, whether it is in their home country (due to lack of infrastructure or emigration possibilities) or abroad after migration (Mattoo, 2005). Finally, scholars have developed terms such as "the international mobility of talent (Solimano, 2008)."

Most writing on brain drain and its subsequent incarnations are by economists, policy analysts and political scientists. Sahay (2009) divides this literature into the following categories: studies of the causes of professionals' migration; analyses that attempt to determine the scope and magnitude of this migration; and literature examining the impact and consequences of this migration on sending and receiving countries. He also points out that most of these studies

[34] Brain gain has also been used to describe the effect of migrating professionals to a wealthier country on that country.

are hypothetical, as reliable data on this issue are difficult to obtain (particularly from sending countries) and almost none of the studies obtain information from migrating professionals themselves (22).

While the writers who promote the concept of "brain gain" point to the advantages the emigration of professionals can have for countries of origin, they often mention the departure of health professionals as an example of its disadvantages. After describing cases where migrant entrepreneurs and venture capitalists built bridges for the transfer of technologies, information and resources between wealthy nations and their countries of origins, Solimano (2008) writes,

> "However, not all talent mobility is as glamorous as these examples suggest. A particularly dramatic case is the massive and persistent emigration of medical doctors, nurses, and others workers in the health sector coming from poor nations in Sub-Saharan Africa, from the Philippines and other developing countries who go to work to the UK, US, Canada, Australia, and other developed countries. The negative side effect of this mobility of health professionals is the weakening of the health sector in the source countries. This is particularly serious in the case of Africa, suffering from an AIDS epidemic, malaria, and other diseases that cause loss of human life and impair countries' development potential. This poses conflicts between the private interests of health professionals and the social needs of the health sector in the home countries (3)

These similar conflicts are apparent in Haiti, where an absence of healthcare workers is decried by Haitian and international observers and commentators. The African health conditions described above are also relevant in Haiti.

As Haitian medical residents plan their emigration and anticipated integration into a foreign health system, they are inspired by memories of experiences abroad (only two residents had never left Haiti.) The others had traveled to North America, France, and other Caribbean islands, either to visit friends and relatives, or as part of training during medical school. Those who had spent time in hospitals abroad (primarily in France, or the French territories of

Guadeloupe and Martinique as part of a university exchange) described the experience as very positive, despite some difficulties adapting to a foreign setting and negative encounters with racist colleagues. They were impressed by the level of technological sophistication they encountered in foreign hospitals, as well as the functioning of the establishments they worked in. In the words of a surgery resident: "There were a lot of things that I was seeing for the first time. It was my first experience with scanners, and learning how to read them. Their medical system also really appealed to me, how well everything was managed and controlled." A resident who had spent two months in Montreal during medical school said, "I like the Canadian health care system so much that I want to go back to it. It fosters learning, the academic support is really remarkable."

These experiences also led to frustration and dismay upon returning to Haiti and realizing how little, in comparative terms, was available in terms of diagnostic equipment, range of treatments and resources for patient care. One resident told me,

> "I did a six-week training in Guadeloupe, and it let me see how far we have to go in Haiti. I was at a little clinic, but they have everything, *everything,* it's well-organized, it's terrific. We [in Haiti] are really far from the way that medicine should be practiced. What we do here has some value, because we save lives. It's as though we're doing war medicine. We're always in an emergency. Guadeloupe is small, but they're well-organized, why aren't we? Is it an issue of bad faith, I don't know. But it angered me to see everything that they're doing in Guadeloupe, so close to us, while we're just treading water."

For some of the residents, their experiences in hospitals abroad allowed for first-hand encounters with the practice of medical specialties that are not available in Haiti, areas such as laparoscopic surgery or neurology. In these cases, emigration was associated with the possibility of training and practice in these domains.

The residents' primary reason for wishing to leave Haiti was to pursue economic opportunities abroad. While many also mentioned the desire to further their education and concerns related to insecurity in Haiti, it is ultimately the hope of higher salaries and improved standards of living that attract young Haitian physicians to the United States, Canada, France and elsewhere. It should be noted, however, that Haitian migrants' salaries are often used to support family in Haiti – remittances from overseas migrants, (estimated at 1.2 billion USD annually) constitute a significant portion of Haiti's revenue, surpassing formal aid and income from exports (U.S. State Department, 2010).[35] When these young physicians migrate, it is very likely that they will support their kin network as they themselves have been supported by relatives abroad. Several residents told me explicitly that the higher salaries they would earn abroad would contribute to household income in Haiti, and could be directed toward expenses such as school fees for younger siblings or cousins. These relatively common arrangements contribute to residents' impression that they could contribute more to their home country by emigrating than by remaining there. Nina Glick Schiller and Georges Fouron, who examined Haitian-Americans' sense of obligation toward relatives and kin in Haiti, write about a "morality of knowledge," through which migrants' first-hand knowledge of conditions in the country they have left behind serves as grounds for efforts to help remedy the situation. They claim that in the context of migration and obligation, "a person's humanity is defined by their acts of helping

[35] The quantity of remittances sent to overseas migrants is difficult to estimate, as these often do not pass through official channels. The importance of international aid in relation to other forms of revenue may increase as a result of the January 2010 earthquake, however funds disbursed are often less than those officially pledged, and are often used for expenses outside of Haiti, such as imported materials or salaries for foreign experts.

others." As one of their informants explained, "Naturally, it's an obligation [to support people in Haiti]. It is because you left your close relatives here in poverty. The people you left behind must survive, and you must have a certain humanity in your heart. You are obligated to send a little something for that person to survive… That is a necessity because you left them and you know what conditions they are living in (Glick Schiller and Fouron, 2001: 78)."

Many residents spoke of migration as a temporary strategy that would lead to an eventual return to Haiti. The resident who had gone to Montreal told me,

> "These days, I'm really disgusted by the system here, and that gives me momentum to go back [to Canada], to take the equivalency exams. But that momentum hasn't killed my desire to work for my country. I need to go get some experience, to be sure. I need to make enough money, come back here, and set up a serious hospital, one that complies with international regulations, so that patients don't have to be responsible for getting sheets for their beds or getting food to eat. But for now, after my residency in Haiti, I think I'll spend at most a year or two in Haiti, then I'll leave to get some experience abroad, and after a while, come back to my country to settle down.

Such narratives are common among Haitian migrants, whose departure from Haiti doesn't preclude continued involvement in the country's economic, political, and social life, either as residents abroad, or as eventual returnees to Haiti (Glick-Schiller and Fouron, 2001). In most cases, migrants choose whether or not they will remain involved in affairs in Haiti, and what form this involvement might take. In some cases, however, this involvement is determined by a contractual agreement.

**International Aid and Contractual Return**

With the training of Haitian health professionals identified as a priority by a growing number of international actors, a growing number of foreign

organizations and governments are providing training for Haitian health professionals, both in Haiti, and abroad. These programs are intended to remedy a dearth of opportunities for aspiring health workers in the Haitian education system. Entrance into Haiti's medical and nursing schools is extremely competitive, with very few openings compared to the number of demands. In order to qualify for entrance, students must have completed high school, which requires a significant financial investment for most Haitian families. Tuition represents another expense, as do living expenses for students who relocate to pursue their studies. (All of Haiti's four medical schools are located in Port-au-Prince, as are many of its nursing schools.) I often heard criticism about the quality of medical education from Haitians trained in the system as well as by international observers: major problems include a lack of pedagogical resources, professor absenteeism, interruptions due to strikes and instability, and a focus on theoretical training that left students without hands-on or practical experience. For all of these reasons, international bodies, both governmental and non-governmental, have been active in training Haitian health care workers through a variety of initiatives.

The best-known and largest of these programs (in terms of number of students) is sponsored by Cuba. In 2004, the Cuban government, as part of its ongoing efforts to support Haiti's Ministry of Health and its establishments, began offering free medical education to selected Haitian high school graduates. The program aimed to recruit students from throughout the country, and selects candidates through a competitive examination held in all ten of Haiti's

departments. Approximately one hundred students are selected annual based on their examination scores (as well as a much smaller number based on the discretion of officials in the Ministry of Health) and receive five years of medical education, housing, and board at the Escuela Latinoamericana de Medicina's campus in Santiago de Cuba. There, they form the largest group of students among a cohort that includes students from Africa, Latin America, and a small number of Americans. As part of this arrangement, Haitian students must sign a contract that obligates them to return to practice medicine in a public establishment in their area of origin for at least five years.

Other, smaller-scale training initiatives include scholarships by churches or private organizations that will sponsor a promising student's medical training in Haiti, programs through foreign universities that will host a Haitian student for periods ranging from two weeks to several years, and programs in Haiti such as the HUJ's Family Medicine resident training program, which offers advanced medical training for students in Haiti by drawing on the resources of a foreign institution or government (in this case, the Florida-based university, USAID, and other funders). These programs may or may not have a contractual clause included in their arrangements that secures the trainees' staying in or returning to Haiti upon completing the training. Enforcing these agreements is not always simple – I was told of one case where a private American foundation paid for a medical student's medical education in Haiti in exchange for the student's commitment to work at the foundation's rural hospital. The foundation pressed criminal charges when the graduate refused to fulfill his contractual obligations.

Eventually, the case was resolved when the young physician reimbursed the foundation for the cost of his studies.

I asked the medical residents for their perspectives on subsidized medical training in exchange for a commitment to work in Haiti. None of the residents has signed a contractual agreement to remain in Haiti after their training, but two of the largest groups of residents, those in family medicine and those in pediatrics, were in programs that were being supported by foreign organizations (an American university and Konbit Sante) whose support of the residency was explicitly intended to contribute to the Haitian medical force, and in the case of family medicine, encourage trainees to work in rural, underserved settings. The residents were aware of this dimension of the program, but their reflections on these issues remained personal and pragmatic. More than abstract reflections on debt and obligation, the reflections they shared with me focused primarily on pragmatic concerns:

> Resident: Unfortunately, a doctor has needs to live too, he can't just sit anywhere. That's why most family doctors work for NGOs… they have scanners, they have equipment. And that's where they really play the role of family doctors, they see people, and after, they call on specialists. The state should organize things this way. But family doctors are all in NGOs or private practice, the state doesn't use them. The state hasn't hired a single one yet.
>
> PM: Would a doctor accept to go work in a rural area if there's a good salary, even if there might not be infrastructure, or good schools in the area?
>
> Resident: If there's enough money, he'll work something out. He can see his family on weekends. Because his heart was formed for work. That's what we're trained for, for rural work.

The residents made explicit ties between living conditions for medical professionals and state responsibility. A resident explained to me:

> The state has to make conditions suitable for them to stay. They're not leaving because they don't love their country, because they don't love their brothers, but because the conditions aren't there. Your whole family has its eyes on you. You're an investment for it, your little brothers and sisters. The conditions have

> to be there for you to be able to work and look after people's needs. If the conditions aren't there, if there's no water, no electricity, they don't pay you well… I think those are the reasons why doctors leave. If it weren't like that, doctors would stay in their communities and give service, they would stay, and help others. Abroad, it's good, people respect your work. But it's not without sacrifice, because sometimes you feel like they humiliate you, you feel like you're not at home. You're more appreciated in your own country, by the patients. The leaders don't appreciate you at all, they don't respect you, they don't understand that if you work you need to eat, drink, to have electricity and water. I think those conditions exist abroad, but not here. It's not because they don't love their country. It's because the state doesn't take its responsibilities. What you don't find here you'll find elsewhere.

While most of the residents were opposed to the establishment of contractual agreements stipulating a trainee's return to Haiti, a few supported the practiced, while dismissing its relevance for their own lives:

> Resident: Those programs are good, because usually, given the little that's offered here, we lose the benefits [of training healthcare workers], we always have the same problem. Foreign countries have enough, here, we're lacking. It's a good thing, something to promote. Haitian doctors have to be encouraged to stay in the country, and we'll have improvements in health.
>
> PM: Would you have signed this kind of agreement?
>
> Resident: I already have a desire to stay, whether or not there's a contract. A contract isn't what's going to make me stay, I *know* that I have to stay.

While this resident hoped to stay in Haiti and work for an NGO, she confided that her husband, also a physician, was preparing to take the USMLE.

Other concerns expressed by the residents included what they perceived as limited opportunities for intellectual and academic growth if they were to stay in Haiti. In the words of a pediatrics resident: "To tell us that we have to stay here after only getting this training? No way. We have to go see how things are better elsewhere, we have things to learn." This concern was also reflected in comments about what many residents perceived to be "real medicine."

**"Real Medicine"**

A recurring theme among Haitian medical residents was the difference between the medicine they practiced on a daily basis at the HUJ as compared to the medical practices they had experienced during periods abroad, or to a lesser extent, in private establishments in Haiti. During trips to Paris, Miami or Montréal, they had seen "*la vraie médecine,"* (real medicine) or "*la médecine du 21ième siècle"* (21st-century medicine). In contrast, as one resident told me, "We're doing 20th-century medicine. I don't even know if I could call it that. This isn't medicine at all." For most of the residents, the difference lay in technological advancements. Coming from a hospital where the single X-ray machine was inoperative for months at a time, working in an environment with complex monitors, sophisticated scanners, and cutting-edge equipment made a strong impression on the young Haitian doctors. Working in a foreign operating room and having the appropriate surgical equipment meant not having to fish around in a bin and find an approximation of the desired tool as they regularly had to do at HUJ. Many spoke of the availability of a wide range of laboratory exams. While Haitian physicians are recognized by their Western colleagues for being outstanding at empirical diagnosis due to the lack of laboratory tests and equipment, they also experience the frustration of not having the certainty of having made a correct diagnosis. "We have to start treatment and hope it works," one physician told me, "but often the patient doesn't return and we never know what she had." Overall, the residents' descriptions of the "real medicine" they encountered abroad focused on the presence and availability of sophisticated biomedical technologies, and their use to diagnose or treat conditions that may

have been impossible to address in Haiti. "It's like what we learn about in our studies, but never get to do in practice," one resident told me.

An ironic dimension of the residents' interest in "real medicine" is that it is mirrored by many of the medical aid volunteers who come to Haiti from wealthier countries. I often heard these volunteers describe their activities in Haiti as being more valuable and worthwhile than their medical activities in their home countries. Encountering and treating dramatic or life-threatening conditions such as neglected congenital deformations, lethal diseases, and severly debilitating pathologies was described by these informants as "real medicine" or "important" in comparison to the routine, chronic, and relatively benign pathologies many of them encountered in their home practices. Such discourse related to authenticity and impact frequently appears in the promotional materials of aid groups and organizations, which encourage potential aid volunteers, workers and supporters to "change lives," "save a child," and "make a real difference." While foreign health professionals in Haiti are often perturbed by the lack of resources and technology available there, I have also heard several state that working in such conditions allows for the emergence and development of "real" medical skills, such as diagnosis based on direct observation and treatments that rely on practitioners' resourcefulness and flexibility.

A third and final area that illustrates the complex interplay between Haitian and foreign medical professionals and the diverse systems of values that are at play in their work involves patient preferences for their practitioners' nationality and origin. Although it seems likely that there would be instances in

which patients would be apprehensive about consulting a foreign clinician and would prefer to receive care from a Haitian clinician, the encounters that were recounted to me (and which I observed while following foreign medical teams) more often involved a preference by patients for foreign rather than Haitian medical staff. In one instance, a Haitian resident recounted an experience at a rural hospital that regularly received teams of foreign health workers. When she began calling out patients' names in the waiting room to begin her day of consultations, no one responded. After several names had been called, she asked the waiting crowd what was going on. "*N ap tann blan yo!"* (We're waiting for the foreigners!), someone called out. The resident laughed as she told me this anecdote, but it was clear that she had been wounded by the episode. While the majority of residents' complaints about feeling under-appreciated involved the state, the country's leaders, and the hospital's administration, several residents complained about patients not "giving our work any value." The episode above was particularly hurtful in that the resident felt that she had far more experience with the kinds of pathologies that typically brought patients to the rural hospital than did the foreign clinicians, and would be able to communicate more directly and effectively with them.

Foreign clinicians, particularly those who came to Haiti for short trips, were often not aware of these dynamics, as many of these comments and conversations happened discretely and in Creole. In one instance, however, I witnessed an American team hear from a translator that a patient refused to see the team's Haitian partner physician, but wanted to see a foreign doctor instead.

After an uncomfortable silence, an American nurse indignantly told the translator: "Well, you tell her that if she doesn't want to see Dr. Jean-Louis, she can just go home!" This type of situation occurs in teams that work with local Haitian practitioners. Teams that do not include Haitian members and do not partner with local health establishments also may lead patients to make choices about the care they seek. The administrator of a rural hospital complained to me about such teams, saying that patients would often delay seeking care (for periods of several months) in a Haitian clinic or hospital knowing that a foreign team would be coming to the area eventually. She bemoaned the fact that such groups often didn't keep any records, had little first-hand knowledge of local pathologies or treatments, and often dispensed medical services for free, along with food, clothing, and school supplies. The administrator felt that such practices led to unrealistic expectations of or resentment towards establishments such as the one she directed, which charged nominal consultations fees and attempted to limit the number of material goods they dispensed in an effort to avoid creating dependency.

**Admiration and Obligation**

Haitian health professionals, specifically young physicians, are caught between a number of diverse and sometimes conflicting pressures: their sense of responsibility towards their families, their desires to continue learning and gain access to sophisticated biomedical practices and technologies, aspirations towards comfortable and secure lifestyles, and sentiments of nationalism and compassion

that motivate them to serve their country and improve the conditions of their compatriots. How and if they will succeed in addressing these pressures remains to be seen. To better understand the values that guide their decision-making processes and choices, I asked each resident to describe a physician whom they admired, and who they looked to as a model for their own future careers.

Training is a central component of the residents' lives and work. In theory, residents at the HUJ are to be trained by the hospital's attending physicians, who are supposed to conduct and participate in rounds, hold formal training and workshops for the residents, and supervise the latter's daily tasks and activities. In practice, however, the high rate of absenteeism among attending physicians means that residents are left without any training or supervision. Notable exceptions included pediatrics and internal medicine, where physicians paid by Konbit Sante were explicitly responsible for training residents, and Family Medicine, a service that was created by faculty at an American university as a training program for residents in this branch of medicine. In other services, training was haphazard – residents might benefit from the dedication and commitment to training by one or two physicians in the service, but for the most part, were left to learn from textbooks, more senior residents or hospital staff, and their own experiences. While these residents had grown accustomed to the lack of supervision and mentorship from attending physicians, it remained a source of frustration and disappointment. Residents also resented that attending physicians received higher salaries with fewer delays in payment, despite the fact that residents' presence in and contributions to most service was much greater. One

resident related an incident in which she approached a man in a ward and asked him rather aggressively why he was leafing through a patient's chart. His response, that he was an attending physician, embarrassed both of them – the resident, for having spoken to an attending physician in an abrupt manner, and the attending physician, for being unfamiliar to the resident despite the latter's constant presence in the service for over a year.

It is perhaps because of these configurations that those physicians who were present as supervisors and mentors were especially appreciated, and also why many residents told me that there were no physicians at the hospital whom they admired or who served as a model for their own professional aspirations. Others said that they had had a professor during medical school that they admired, but that there were no models for them at the HUJ. Several told me that they would like to have the individual qualities of several physicians, but that there was no single doctor that they particularly admired. Those who did name a physician almost always named one from their own service, and certain physicians were named repeatedly by the residents. When I asked about admirable qualities that either characterized specific physicians or were appealing as abstract qualities, the residents gave a diversity of answers. Not surprisingly, residents appreciated those physicians who actively participated in the training, and who acted as mentors. Residents explained that senior physicians who "take the time to explain things" and "don't keep what they know for themselves" were particularly appreciated. Other commonly-mentioned qualities include attention and commitment to patient care, staying current with current medical research

and techniques (several residents used the English expression "up-to-date") and finally, being able to manage interpersonal relationships. This involved both being able to avoid or work through potentially conflictual situations, but also to stick up for one's own interests, and not be taken advantage of or pushed around by colleagues or superiors.

In terms of mentors, supervisors, and senior colleagues, young Haitian physicians today work with a reduced pool of health professionals due to decades of emigration. It is not uncommon, particularly in smaller clinics and dispensaries, for physicians fresh out of a year-long internship to be the sole biomedical provider in the establishment, or in the cases of very rural areas, the entire community. The residents, all of whom had completed a year of social service in a rural setting, often had negative memories of these experiences. They recall being overwhelmed by the health conditions they confronted, the lack of resources available to address them, and personally challenged by shortages of water, electricity, and at times, food. Isolation from family and friends meant not having access to the support networks that can and do cushion these kinds of hardships. Not having the mentorship, support or advice of more senior physicians left them feeling incapacitated and discouraged, sentiments that I commonly heard expressed at the HUJ, despite its position as one of the country's largest health establishments, and one of the few university teaching hospitals in Haiti. Meanwhile, colleagues who had emigrated, either before or during medical school, write back with reports of high salaries, access to sophisticated biomedical technologies and cutting-edge training, and a plethora of

opportunities for intellectual growth and personal advancement. It was comparison with situations like these (which for many of the residents appear to be in reach) that prompted the following reflection from a surgical resident: "I'd like to stay in my country to be able to give my help, in my way, but I don't know what the leaders of the country will say to me. You can have every desire to stay, they'll find a way to discourage you. If that were to happen, I don't know where I'll end up… Europe, Canada, the US, I don't know… a place where they need me."[36] This was not the only young healthcare worker who told me that he or she did not feel "needed" in Haiti. This lack of need did not apply to the general population's health status or medical conditions: all of the Haitian healthcare workers I spoke with were aware of the dire health conditions faced by their compatriots and the lack of resources and treatment options that exacerbate the many preventable pathologies that cause high rates of morbidity and mortality. Rather, it referred to the Haitian state's perceived incapacity or unwillingness to provide or ensure the conditions that would permit healthcare workers to practice their occupation in what they consider to be decent conditions, and with acceptable remuneration.

Haitian healthcare professionals participate in transnational networks in a variety of ways: as the recipients of support for migrant kin, as participants in overseas trainings and internships, as aspiring migrants, and as the targets, administrators and implementers of international interventions in Haiti. In these

[36] The Creole term *bezwen* (from the French *besoin*) that was used by the resident can also be translated as "want" in addition to its primary meaning "need." "Want" is more often expressed with the terms *vle* (from the verb *vouloir*) or *anvi* (from *envie*). However, the two possible meanings of *bezwen* highlight the blurriness that distinguishes needs from wants.

last roles, they represent key nodes in the aid process, specifically as intermediaries between the providers and recipients of aid. They do so while making claims on the Haitian state to fulfill its responsibilities and obligations, while remaining pessimistic about its capacity to do so. They, like others involved in international health interventions, decried a lack of coordination in the medical aid process. The issue of coordination and its perceived absence despite unanimous calls for it is the subject of the following chapter.

## Chapter 4 Coordination and Un-Coordination

The issue of coordination was not a topic of particular interest when I began this research. It soon emerged, however, as one of the most prominent subjects in the discourses of my informants. What I found particularly striking was that, compared with other issues of shared interest or concern, the issue of coordination was spoken about in remarkably consistent terms by a diversity of informants involved in medical aid, whether they were Haitian, foreign, donors, recipients, volunteers, professional aid workers or even casual observers. I have also noticed that public commentary on the issue of coordination of international medical aid (and international aid more broadly) by directors of large aid organizations, governmental leaders, analysts and journalists also echoes the homogenous discourse of my informants. When analyzing what I have heard and read about coordination, three general claims emerge: 1) The coordination of international medical aid in Haiti is minimal, insufficient, or completely lacking; 2) This lack of coordination has undesirable direct and secondary effects, including waste of resources, unnecessary duplication of services, and negative consequences on the health of Haiti's population; 3) Increased coordination would be completely advantageous, bringing benefits for a currently lamentable and unacceptable state of affairs.

As one Haitian physician told me:

> "Here's why coordination is important: International aid groups send us certain kinds of material, but we don't really use them. If only there were better coordination with the hospital administrators and heads of each ward… They send us a lot of the things we don't need, and we never use them. They could send us the things we do use; there are a lot of things we're lacking. I think

> that's a lack of coordination. Coordination is so important. If there's good coordination, it lets you see the results of the aid you're giving."

Another said,

> The problem is duplication. You have multiple NGOs that are intervening in the same area, and the problem still doesn't get solved. It would be better to present a specific problem to the funders. People come and ask you what problem you have, you say that you have all kinds of problems, and someone else comes, and it's the same thing again. What if you were to give a group a single problem instead? People shouldn't come to ask what problems there are. Also, the hospital leadership changes often, so they only do things that are visible. People say, "Oh, the hospital's nice, it has lights," but nothing's changed. If a group were to take a few days, take a single problem, focus on it, document it, write about it, then say, "Donor, can you help with this problem?"

Similar themes appeared in the discourse of a third Haitian physician:

> We don't know what we want, and when we start doubting, that makes aid move backwards, because no one knows what we want. So come to an agreement, and after we'll see. This is crucial when aid is coming in. What happens is that there are a lot of organizations working in the dark, and each person what he or she wants. The state isn't capable of taking control of the situation, to say, "Ok, everyone's under my control. You have to do this, you do that, we have to meet once a week to report on what's not been done." It's common to see five or six organizations in an area, each person doesn't what they want, sometimes there are even collisions among the aid groups. Something already existed, we find others doing more of the same, it leads to surplus, it leads to chaos. Coordination is essential.

Overall, Haitian medical staff identified a lack of coordination as contributing do the donation of unnecessary or useless items by foreign aid groups and agencies, as well as the duplication, redundancy and waste of resources. A lack of coordination is also decried by individuals working outside the medical sector. A lawyer in Cap-Haïtien listed the lack of coordination of foreign aid as one of many problems plaguing biomedical services in Haiti. At times, these critiques from outside medical establishments identify medical workers as responsible for or benefiting from this lack of coordination, such as when hospital employees pilfer donated supplies for use in their private clinics, or charge fees for services that have already been subsidized by international bodies.

Foreign informants echoed their Haitian counterparts' complaints about the negative consequences that result from a lack of coordination. As mentioned

in the previous chapter, established groups and organizations often resent the arrival of of new teams that periodically came through the former's catchment areas to conduct mobile clinics and distribute vitamins, medications, clothing, and other goods. These groups generally don't have access to patients' medical histories and rarely create their own documentation, are often unfamiliar with the pathologies that are most frequent in rural Haiti, and don't always make provisions for follow-up care. Coordination for many foreign informants involved (among other things) new or recent aid initiatives gaining awareness of existing services in an area, and working with them, rather than on their own. For many foreigners, such as the members of Konbit Sante, these existing services include state-run public establishments, and MSPP should be the entity responsible for coordinating all health activities in the country.

While discourse about the importance of aid coordination in Haiti has proliferated among aid organizations, government agencies, and in North American print media since the January 2010 earthquake, it can be traced in its current form to the mid 1990s. Specifically, the end of the US-initiated international embargo in 1994 on Haiti led to the resumption and initiation of diverse international aid initiatives (ICF, 2004: 5, 44). In 1999, a UN advisory group on Haiti found that:

> Strengthening the leadership role of the government in aid coordination is key to making Haiti's cooperation with its international development partners more effective. Decades of institutional instability have adversely affected the coordination capacities of the government accumulated in previous years. The situation steadily further worsened following the 1991 military coup when the constitutional government went into exile and the void in development was filled by international donors and NGOs. Since the return of the constitutional government in October 1994, the institutions officially charged with aid coordination have found it increasingly difficult to effectively coordinate the activities of most external partners. This is partly due to donor-driven initiatives

> and the fact that many of these partners, including some non-governmental organizations have not yet shed the isolated operational practices adopted during the embargo years (UN Ad Hoc Advisory Group on Haiti, 1999).

Responses to devastating floods in the city of Gonaïves also brought the subject of coordination to the fore. Coordination was the primary topic of international meetings and conferences: a 2007 meeting hosted by the World Bank and the Government of Haiti convened representatives from nine nations, the European commission, the OAS, the IMF, the PAHO and the UN (World Bank, 2007). The purpose of the meeting was to discuss coordination between donors and the Government of Haiti, as well as among donors themselves. In 2009, the Government of Mexico hosted a "Hemispherical Conference on Coordination for International Cooperation with the Republic of Haiti." The same year, the Canadian Minister of International Cooperation reported after a trip to Haiti: "I'm proud that Canada is taking leadership on Haiti, especially on improving coordination and coherence among donors to ultimately deliver results… By working together, we can seize upon a unique opportunity to bring hope to this country (CIDA, 2009)"[37]

If the diverse actors involved in international medical aid to Haiti agree on the importance of coordination, why does this lack of coordination (real or perceived) persist? How should we interpret the apparent discrepancy between a unanimously identified objective and its elusive achievement? I propose four possibilities.

[37] Calls for increased coordination of aid during this period were not specific to Haiti: in 1991, the UN formed its Office for the Coordination of Humanitarian Affairs. In 2002, this body organized a "Symposium on Best Practices in Humanitarian Information Exchange" in Geneva.

The first is that my informants and other commentators are speaking disingenuously. That is to say, they are not sincere in their statements that they favor more coordination, but simply say so because of pressures to decry the lack of coordination. I do believe that a position in favor of increased coordination is one that is popular and appealing to even those people not directly involved in aid in Haiti. It resembles stances taken against corruption, or pollution, or delinquency. A person expressing the opinion that there is sufficient or excessive coordination (or that increased coordination would have negative consequences) would be expressing a dissenting opinion, and would certainly face rebuttals or challenges to justify these opinions. The term is often used without precision by commentators, who decry its lack without describing what coordination in this context would or could entail (and may very well be earnest and sincere in their indictments). My informants, however, were able to give precise examples of what coordination would entail, and what benefits it would bring. They provided specific anecdotes of instances when unfortunate events occurred as a result of what they identified to be a lack of coordination. I also heard of and witnessed firsthand efforts to coordinate medical aid initiatives, which I will describe below. As a result, I believe that when most people who have direct experience with international aid in Haiti decry a lack of coordination, they are genuine in their claims and base their opinions on empirical examples.

The second possibility is that coordination exists, but it is not identified as such by commentators. I believe this to be partially true, in the sense that much of the coordination I observed during my research, including the sharing of

information, collaborations on specific initiatives and projects, and harmonious interactions between diverse actors was informal and localized, and would not be recognized as coordination on a larger scale. The issue here may be one of scope: when my informants decried a lack of coordination, their frame of reference was often Haiti on a national level. The same is true in reports by outside analysts and commentators: many of those calling for increased coordination may not perceive or acknowledge the diverse forms of collaboration and coordination that take place on a small scale or outside of formal institutional frameworks. However, many informants complained about a lack of coordination at the local or regional level as well, citing examples when organizations or agencies operating in a specific site act in ways that appear uncoordinated.

The third possibility is that coordination of international medical aid in Haiti is simply impossible, either due to the scope of the actors involved and the scale of their areas of intervention, or because of the actors' own personal limitations and shortcomings. In addition to state actors (various branches of the Haitian government, foreign governments, the United Nations and its numerous agencies), the number of NGOs in Haiti is commonly cited as a factor impeding the coordination of aid efforts. While 495 foreign NGOs are currently registered with the Ministry of Planning and External Cooperation (a significant increase in the last five years [Schuller, 2007: 45; Jerôme, 2011]), the estimated number of non-registered but active NGOs ranges from 3,000 to 10,000. These calculations generally do not take into account Haitian civic or non-profit organizations, or, in the case of health care, private clinics or health establishments. While this scope

is daunting, and the coordination of so many diverse actors is difficult to envision, dramatic improvements in telecommunications (primarily through cellular phones) and new internet-based technologies have greatly facilitated logistical dimensions of communicating and coordinating in Haiti. These and other technologies are recognized for their potential role in improving coordination. At the World Bank meeting mentioned above, "[f]or strengthening capacity to coordinate, it was agreed that technical assistance [from international donors] will be of great importance." While recent innovations in communication and information management remain inaccessible to many people in Haiti, they have facilitated communication and coordination among key players and stakeholders, and will continue to influence how coordination occurs. Since informants could often name precise situations when coordination was possible but did not occur, this third possibility offers only a partial explanation.

The fourth and final explanation to explain the discrepancy between a call for increased coordination and its persistent absence is the one to which I will devote the greater part of this chapter: the number of compelling incentives for foreigners and Haitians involved all dimensions of international medical aid to not coordinate. Phrased in more positive terms, these individuals and organizations have a variety of reasons to favor autonomy and discretion over coordination. I will begin by describing some of the more obviously pragmatic considerations that influence whether or not coordination takes place.

### 4.1 Language, Time and Leadership

Language poses a formidable barrier to the coordination of international interventions in Haiti. Very few foreign aid workers or volunteers in the country speak or understand Haitian Creole. This is true even among those who had significant or long-standing involvement with Haiti: I met a physician who told me that he was on his 104th trip to Haiti, but could not function in the country without a translator. The same was true for another physician who had been travelling to Haiti for nearly twenty-five years. In Port-au-Prince, I met employees of government aid agencies and large aid organizations who had been living in Haiti for several years who were unable to introduce themselves in Creole. The short-term volunteers I met often knew simple phrases and expressions, but the only foreigners I met who were able to communicate fluently with Haiti's unilingual Creole majority were those aid workers, missionaries, and researchers who had lived for significant periods in rural Haiti. There are several factors which explain these phenomena. There are relatively few resources for learning Creole outside of Haiti, particularly if one lives in an area without a significant Haitian immigrant population. In addition, Haitian Creole's status as a stigmatized language – one which developed only three centuries ago under colonial slavery, and whose speakers today are for the most part marginalized, impoverished, and illiterate – may play a role in its lack of uptake by foreigners. A Belgian aid worker confessed to me, "Whenever I speak Creole, I feel like I'm speaking bad French." Many foreigners I met in Haiti were uncertain if Creole was a "real" language, a dialect of French, or a "broken French."

For those foreigners who do learn Creole, even this may not be enough to overcome language barriers. As mentioned in the introduction, while Haitian Creole is the mother tongue of nearly all Haitians (the exception being a small number of French/Creole bilinguals), French remains the language for official communication in elite spaces, such as schools, government establishments, courts, and health centers. Although estimates of French fluency among Haitians are generally below fifteen percent of the population, the language remains entrenched as a powerful symbol of privilege and power (Valdman, 1984: 77-82). French is commonly used among hospital staff, in formal presentations and meetings, and in most Haitian texts and documentation, both governmental and non-governmental. While French and Haitian Creole are closely related (the former is the source of most of the latter's lexicon), they are not mutually intelligible. I encountered several American aid workers who became fluent in Creole, but who experienced frustration at not being able to participate in interactions in French, which were often formal, official, and had high stakes, given that they often took place in sites of decision-making and power.

For some international aid workers and volunteers, communicating in Creole or French is simply not a priority. An American doctor once told me, "We speak the same language: medicine!" For those working carrying out specialized surgical procedures, most of their contact with Haitian patients may occur when the latter are unconscious. Oftentimes, foreign volunteers are able to communicate with Haitian health professionals in English, as many of the latter (particularly physicians) speak or at least understand English. Nevertheless,

language barriers in international interventions are real, and I observed countless cases where, despite the presence and hard work of competent translators, meanings were distorted and intentions misread. While translation can facilitate formal meetings, it is largely inadequate for the kinds of casual conversations and informal encounters that build collegial and amicable relationships and lay the foundation for collaborations. Not surprisingly, most of the effort I've witnessed to learn another language has been on the part of Haitians, who recognize that proficiency in French, English and Spanish has numerous economic and social advantages.

Having received a relatively high level of formal education, all of the Haitian health professionals I met spoke French (although it was sometimes faltering for those who did not use it regularly). As mentioned above, most of the physicians and administrators I met could understand English, and many of the younger professionals spoke it quite fluently. English is a required subject in the Haitian education system, and the language has also increased its presence in the country through the continual back and forth migrations of Haiti's large diaspora. In cases where aid groups did not work with English-speaking Haitian medical staff, they usually found young men to work them as translators, generally high school students or individuals who had spent time abroad or had prior contact with foreign tourists or aid workers.

Language, therefore, became a major obstacle to coordinate the diverse parties active in medical interventions in Haiti. The four most relevant languages were Creole (spoken by the entirety of the Haitian population and the sole

language of a majority of Haitians), French (used in elite spheres in Haiti and used by aid workers and volunteers from France, Québec, Belgium, and Switzerland), Spanish (used by Cubans and the Haitian graduates of Cuban medical schools, Spaniards, Venezuelans, Dominicans, and other Latin Americans), and English (used by Americans, Canadians, aid workers from various countries, and members of the US Haitian diaspora who don't speak Creole or French). Among other factors, the possibility of becoming fluent in a new language depends largely on time, both in terms of time devote to learning, and the overall duration of the period consecrated to learning and practice. Time in and of itself is an important factor that influences the coordination of international medical aid in Haiti.

Many of the foreigners involved in interventions in Haiti do not live there full time. This is particularly true in areas such as Cap-Haïtien. While governmental aid agencies and leaders of large aid groups do have expatriate employees, these tend to live in Port-au-Prince, and are far outnumbered by Haitian staff. In other parts of the country, aid groups rely almost exclusively on Haitian staff, and foreign personnel and volunteers typically come to Haiti for short, periodic trips.[38] While some of the directors and leaders of these groups spend up to several months of each year in Haiti, many are there for only a few weeks per year. Even leaders who spend significant time in Haiti often break up

[38] There are exceptions to this model. Among them are the Cuban medical brigades, which send hundreds of medical professionals to Haiti for two-year periods, and long-term North-American Christian missionaries. Foreign Catholic missionary clergy typically lived in Haiti for several decades, although this group is decreasing in size due to aging and death. There were a small number of American Protestant missionary families living in the Cap-Haïtien area, generally involved in running orphanages and schools.

these stays into many short periods to manage work and family obligations in their home countries. As a result, when these leaders are in Haiti, they usually have an enormous amount of tasks to accomplish in relatively short periods of time. It is not unusual to see group leaders working 20-hour days in Haiti, with tasks that include filling out paperwork, purchasing supplies, carrying out assessments, and providing orientation and guidance to new employees, group members and volunteers. In addition, leaders may be providing clinical services and other forms of aid to an unending stream of patients and solicitors, whose number always grows as the word spreads that a foreign aid worker is present, especially when the worker is one with access to resources and decision-making power. Finally, the leaders of foreign medical aid groups spend much of their time in Haiti in lengthy meetings.

Various types of meetings are among the most time-consuming activities for aid workers and volunteers, particularly for leaders and other members with authority in the group. These include meetings with local staff and partners to discuss programs and working conditions, discussions with government and other authorities, and internal meetings (particularly if teams of aid workers from disparate locations outside of Haiti have come together to work or volunteer). Because meetings are both occasions where coordination can take place and time-consuming events that can preclude the possibility of coordination, it is worth discussing them at length here.

Meetings in Haiti are notoriously lengthy. While people in Haiti (like anywhere else), engage in rapid informal negotiations and come to quick

agreements in hallways and courtyards and from the windows of passing vehicles, formal meetings often last for many hours. Meetings between speakers of different languages take even longer because of translation (sometimes between more than two languages) and the need to clarify resulting misunderstandings or ambiguities. Tardy arrivals lead to meetings often starting late.[39] Meetings often begin with a song and a prayer, particularly if they take place in rural areas or under the auspices of a religious establishment or organization. This is generally followed by self-introductions by each of the participants. Detailed agendas are rarely established ahead of time, and participants often have only a very general idea of what will be discussed. I often sat in on meetings where participants confessed that they did not know why they were at the meeting, but had simply been told to attend by a superior.

Once the introductions are completed, a leader figure typically begins by announcing the topic of discussion, providing background information and raising issues related to the topic. This person is generally the individual who convened the meeting, or a person of high status (oftentimes an older man). Formal meetings, particularly in urban areas or those which include bilingual participants, usually begin in French, even in the presence of mono-lingual Creole speakers. It is not uncommon, however, for the participants to switch into Creole at a certain point in the meeting. A Haitian-American physician humorously described what

[39] Tardiness by Haitians is a common topic of comment and humor by internationals in that country. As in other settings, terms such as "Haitian time" or "island time," imply an inherent disjuncture between one's own notion of time and that of an often racialized or localized other. These comments do not take into account the structural and material constraints that conflict with a strict adherence to a pre-established schedule: bad roads, traffic, vehicle breakdowns, and various types of urgent situations and emergencies related to resource scarcity. During the years I have worked in Haiti, I have noticed the impact cellular phones have had on scheduling. Not only do the phones tell time, they also permit to inform others of delays and allow for re-scheduling

she the moment at which speakers switched from French to Creole, a move that both resulted from and contributed to more animated discussions, heated exchanges, and direct communication.

An important feature of many meetings in Haiti is the expectation that all participants be allowed to express themselves and comment on a given situation. This is not to say that pre-existing hierarchies, interpersonal tensions, or other factors constraining an individuals' capacity to speak in a group setting disappear. Rather, it became clear during my research that most practices of exclusion took place before meetings convened, so that if an individual was present at a meeting, it meant that the organizer or organizers had taken the participant's presence and potential contributions into account, as well as his or her discretion in regards to any sensitive material that might emerge during the meeting.

These assumptions led to some uncomfortable situations when foreigners organized meetings. In many of the Haitian-organized meetings I attended during my work, participants tended to be of roughly the same occupational or social status. Physicians met with other physicians, head nurses with head nurses, and support staff with support staff. In cases such as the latter, the meeting might be run by a higher-level employee or administrator whose authority set him or her apart from the rest of the group, but the other participants were relatively homogenous in terms of their status in the hospital's hierarchy. Foreigners, however, who were often unaware of the specific status and class distinctions that might characterize a group in Haiti, or who felt that meetings between individuals from disparate backgrounds and positions were necessary for the success of their

intervention, might bring together a hospital director, a janitor, a medical student, an ambulance driver and a folk healer for a meeting that would have never taken place under other circumstances. The outcomes of such meetings varied greatly depending on the personalities of the individuals involved, the topic being discussed, and the context the meeting took place in. Some degenerated into shouting matches such as those among clinic staff described by Maternowska (2006: 94-95) while the tone of others remained courteous and collegial.

Talk about meetings, their purpose and effectiveness reflected the ambivalent attitudes both Haitians and non-Haitians had about them. For my Haitian informants, *rankont* or *reyinyon* could be a waste of time -- a seemingly endless set of rhetorical exercises that led to no or insignificant changes in their working conditions. They were particularly critical of *seminè* (seminars) hosted by international groups, because these often took place in expensive hotels and resorts, and exemplified the immoral waste of resources in a context of great scarcity. On the other hand, Haitians involved in international medical aid also appreciated meetings where they felt they could air their concerns and come into contact with the individuals responsible for the aid project. Co-existing with complaints about long, ineffective meetings were frustrations that international donors did not always take the time to listen to Haitians' concerns and ideas, and that there were almost no fora for communicating grievances or suggestions. Exclusion from meetings was also a cause for disappointment and resentment.

International aid workers and volunteers also expressed ambivalence about meetings. They often complained about their length, and about physical

discomforts such as cramped quarters, uncomfortable seats and high temperatures. Translators often began to falter several hours into the meeting (often at the same time the discussion switched into Creole, making the negotiations unintelligible to francophone non-Haitians). The lack of a structured agenda and contradictory input from diverse actors often increased the level of frustration. And yet, meetings represented an important point of direct contact with people that most foreigners involved in international aid often didn't have access to for much of the year. Many have complained to me about the difficulty of getting information from Haiti through phone calls and emails, stating that ambiguous or complex situations are only ever clarified during face-to-face encounters. In addition, for groups like Konbit Sante that prioritize structural changes in Haiti's health care system rather than the provision of clinical services or material goods, meetings are an opportunity to work toward their goals of increasing communication among diverse or estranged parties, streamlining bureaucratic processes, and consolidating ideas and resources to solve health problems. I heard repeatedly from members of Konbit Sante that one of their main goals was to "get people talking to each other who wouldn't be talking otherwise." This statement was not limited to meetings between heterogeneous groups like those mentioned above: both international workers and Haitian hospital staff at the HUJ complained about the lack of regular and routine meetings of the heads of the hospital's various departments. Such meetings tended to only take place in times of acute crisis, such as during the residents' strike or after the 2010 earthquake.

The time constraints that result from many aid workers' relatively brief

trips to Haiti and leaders' packed schedules have played a role in impeding coordination, at least in the sense that they do not allow for pro-active networking and partnership development. International medical aid workers and volunteers that travel to Haiti on short trips generally spend most of their time at their specific intervention sites, and interact primarily with other members of their own group or pre-existing partners. New contacts and partnerships and contacts often develop out of chance encounters. For example, it is not unusual for members of aid groups to strike up conversations with each other in the waiting room at the small airport in Cap-Haïtien. Because of poor infrastructure in many parts of Haiti (particularly in terms of roads, communication, etc), it has been common for foreign groups to be working in the same area without being able to communicate, or even aware of each other's existence. This has changed significantly in recent years with increased availability of cellular phones in Haiti, as well as the increase in internet-based programs and technologies that allow a greater number of groups and individuals to be identified, located and contacted. Now that communication among the various actors involved in medical aid has become easier, and the tools essential for coordinating have become more numerous and more accessible, older questions of leadership and responsibility become increasingly relevant. Who can and should be in charge of coordination?

In the summer of 2008, a volunteer American physician who traveled frequently to a village near Cap-Haïtien sent an email to a dozen foreign and Haitian health professionals active in the area to convene them to a meeting of

what would become the Cap Haitien Health Network[40]. This internet-based group now comprises 120 members, primarily North American health professionals involved in health projects in northern Haiti. Several Haitian health professionals have become members of the network, including the director of the MSPP's northern office, high-level hospital staff, and the employees or partners of international NGOs. The leader of the network organizes meetings three or four times a year in Cap-Haïtien, which are attended by foreign members who happen to be in the area at the time and Haitian and expatriate members who live in or near the city. In addition to meetings in Haiti, the network organizer created an internet listserve for members to share and request information. (The listserve became particularly active in the aftermath of the 2010 earthquake and cholera epidemic.)

I attended the network's second meeting, which was held in Cap-Haïtien's most luxurious hotel. Half of those in attendance were Haitian administrators, clergy and medical professionals, and half were visiting American volunteers, primarily nurses and doctors, as well as two American NGO directors living in Haiti. A representative from each organization was asked to describe their group and its mission. After a few introductions, it became clear that despite the presence of the Haitian participants, the foreigners were the target audience for all of the communication that was taking place. The comment that best exemplified this dynamic was from an American NGO director, who said to the group, "Whenever you're here in Haiti, I hope that you'll let me know, and we'll take you around to different communities."

[40] I use the group's own spelling of its name.

The attendance at the meeting, while intended to include anyone working to address health issues in the area, represented a very specific segment of this larger group, namely mid-level, professional individuals involved in international aid. By meeting in an exclusive social space, and by communicating through foreign NGO networks and internet technology, the meeting effectively excluded individuals who lacked the appropriate contacts or social status. In addition, no representatives of any of the area's three major hospitals were present, or any representatives from MSPP. When I asked the network leader about their absence, he did not recognize the ministry's name, and told me that for the hospital representatives, "I sent them an email inviting them, so they can't claim that they didn't know about it."[41] Conversely, there were a number of foreign volunteers present at the meeting who were on their first trip to Haiti and had limited knowledge about the activities of their own host organizations, and even less about health conditions or medical resources in the area.

While internet-based groups and networks such as the Cap Haitien Health Network will undoubtedly facilitate communication and coordination among certain individuals and groups, it remains to be seen the extent to which they will affect coordination of international aid and Haitian-foreign partnerships more broadly. While internet access in Haiti has increased significantly in recent years, a substantial portion of the population remains illiterate and unable to access computers or internet technologies. This may lead to new divides between those

[41] Since the initial meetings, there has been a greater effort to include MSPP representatives in the network's activities, and the Ministry's local director recently gave a presentation on process through which foreign NGOs must register for official recognition.

who have access to information, networks, and contact and those who do not. In addition, access does not equal use, and I have often heard both Haitians and foreigners complain that their email messages to overseas partners often go unanswered.

Finally, the issue of group structure and leadership is a basic factor that influences if and how the various actors involved in international health interventions coordinate and communicate. As I mentioned in Chapter 1, many of the groups, organizations and agencies I followed were led by a prominent, charismatic leader. While certain groups or agencies like Konbit Sante and large NGOs or governmental agencies have more diffused leadership and decision-making processes (either because of personalities, bureaucratic structures whose size or density discourage charismatic leadership, or frequent turnover of staff), many initiatives were spearheaded by a single individual whose personality, resources and influence were central to the group's operation. This was apparent to the Haitian intermediaries and recipients, who, in addition to referring to a group by its formal name, would often use terms such as "*ekip Doktè Wilè*" (Dr. Wheeler's team) or "*gwoup Natali*" (Nathalie's group). In some cases, the term group or team was omitted, making it sound as though the individual was acting in isolation.[42]

What impact does this tendency have on coordination? While the tendency for groups to be led by charismatic leaders facilitates certain types of coordination in certain circumstances, it can also impede coordination and lead to

[42] This does happen: at times a single physician or nurse will travel to or live in Haiti alone to dispense medical care. They are often affiliated, however, with a Haitian institution such as a church or private health establishment.

many of the factors my informants complained about: isolation, waste, chaos and redundancy. Concentrated and charismatic leadership meant that when leaders encounter a potential partner, they can often make rapid and unencumbered decisions about what type of relationship they could have with such a partner, what resources and information could be shared, and the general terms of collaboration and partnership. For example, if the head of an organization offering primary health care in a small village meets the leader of an organization providing donations of soap throughout Haiti, the former could single-handedly initiate a partnership that would result in soap being distributed in the village in question. While most of the organizations I studied are typically governed by administrative boards, these are generally made up of people living outside of Haiti, whose experience in the country is generally limited and who are often willing to defer judgment about partnerships and programs to the group's executive leader. I observed that a great deal of the collaborative work and partnerships among international aid bodies in Haiti, both formal and informal, are based on individuals' affinities and ties.

The converse reality, however, is that charismatic and concentrated leadership in groups also impedes coordination. As described above, group leaders who do not live in Haiti are generally extremely busy and over-extended during their trips to the country, and coordination is not always a priority. If other members of the group, Haitian or foreign, do not have the authority to communicate on the group's behalf or make decisions about the terms of coordination, it may simply not take place. In addition, the prominence of

individual leaders in the activities of aid groups allows for the development of inter-group conflicts resulting from clashes in personalities and temperaments. Two groups that might have common or complementary goals, activities and resources may operate in isolation of each other because their leaders had an altercation or dislike each others' personalities. (The same, of course, hold true for relationships with Haitian institutions, both public and private, many of which have concentrated leadership.) In some cases, individualist attitudes and a desire for personalized prominence undermine working with other actors.

Figure 4.1 An American doctor leads a tour of the HUJ's internal medicine department for two Nepalese UN physicians, as part of an initiative to direct UN medical resources to the hospital. They are accompanied by two of the HUJ's medical residents, both of whom speak excellent English. The hospital's administration chose not to participate in the tour. The nurses and nursing students (far right) were often excluded from international networking and partnerships. Photograph by Nathan Broaddus.

The factors I have detailed above, language, time and leadership, are pragmatic and logistical considerations essential for understanding the presence or

absence of coordination of international medical interventions in Haiti. These factors are relatively visible to participants in the aid process, even if they may at times minimize their importance. I will now turn to some of the less apparent factors that have an influence on if and how medical aid is coordinated in the Haitian context. These factors are less apparent to casual observers and even to many of my informants, as they involve the subtle management of resources and priorities by actors involved in the aid process, and were often intentionally kept from public view.

### 4.2 "We Don't Have Anyone Else"

Several years ago, a Haitian-American friend who directs a small medical aid NGO received a note from a local peasant woman, one whom she had helped with small gifts of money in previous years. The note, presumably written by someone else on the woman's behalf, described her many economic difficulties and pleaded for money for her children. The final line of the note read: "They'll tell you that we have other people who help us, but it's not true. We don't have anyone else, it's only you." Whether or not the woman did have another source of support (another foreigner, a relative in the diaspora, or a local benefactor) is not as remarkable as the fact that she felt compelled to explicitly disavow the possibility that she might. In considering why a visibly impoverished and desperate woman would employ this strategy when soliciting from a potential donor, one sees similar tendencies among the individuals, groups and

establishments that solicit and receive international medical aid, tendencies that have a direct impact on the coordination of this aid on a broader scale.

There are pressures to keep wealth and resources out of sight in Haiti, and these pressures apply to individuals of various social classes, as well as to organizations and establishments. Money is hidden behind high cement walls, stashed away in boxes or handkerchiefs, or spent through expenditures abroad.[43] One factor fueling this tendency is a fear of violent or forcible removal. While "ordinary" theft has long been an issue of concern in Haiti (*vòlè,* or thief, is among the worst insults used in Haiti, and is used in a variety of contexts), the country experienced a dramatic increase in kidnappings for ransom beginning in the spring of 2005 (UNHCR, 2008). While the levels of this type of crime decreased significantly after the 2006 election, they led to significant fear and anxiety, particularly among middle and upper-class Haitians in urban areas[44]. Items such as expensive vehicles, elegant clothing and jewelry, and lavishly home furnishing represent not only goods that could be taken, but can also act as signals to potential thieves that the owner's family could pull together a significant ransom. I heard several health professionals talk about keeping their dress simple, driving an unremarkable vehicle, and even hiding their occupational status in order to avoid becoming victims of crime. In terms of the hospital's residents, several had been kidnapped, assaulted, or shot in the previous years, and as one of them told me, "All of us [the residents] have been affected by the kidnappings in

[43] "*Gwo nèg yo pa jwi kòb yo ann Ayiti*" (Big shots don't enjoy their money in Haiti)," I was told on more than one occasion.
[44] Poorer Haitians were also targeted, and held for ransoms as little as one hundred US dollars, which represents a significant amount for impoverished Haitians

some way. All of us have family members or close friends who have been victims."

Public evidence or displays of wealth can also attract other forms or undesirable attention, namely solicitations and jealousy. Middle and upper-class Haitians shield themselves from encounters with their more impoverished compatriots by restricting their movements to particular areas and spaces (specifically, private homes, workplaces, exclusive restaurants, and churches), by employing guards and security forces to restrict access to these spaces, and by riding in private vehicles when possible. In instances where they were directly solicited for funds in a public space (when entering or exiting churches and bakeries, for example), I observed physicians at times discretely slip a coin to the solicitor, or announce that they had no money with them. Jealousy, which has been extensively written about in the context of rural Haiti as a source of conflict and sent sickness, was also a regular topic of conversation and concern for professionals in Cap-Haïtien.

In addition to keeping wealth hidden from those who would take or covet it, potential recipients also have reason to conceal existing wealth and resources from potential donors. This is particularly true in the case of international aid, and has a direct impact on its coordination or lack thereof. Aid groups and agencies working in Haiti often make explicit their intention to intervene among the poorest, neediest, and most neglected individuals and populations; in many cases, this intention is what spurred their interventions in Haiti. Haitians who are accustomed to working with these organizations and are familiar with their

missions and mandates take for granted that interventions directed at the most vulnerable and destitute will be of greatest appeal. When visiting establishments or communities with aid groups, I often saw and heard those soliciting aid, either for themselves, or on others' behalf, illustrate need in its various manifestations: a school without a roof, the reddish hair of a malnourished child, the absence of food in a kitchen. These needs were often described as greater or more extreme than any other in the area. While visiting a hospital with a group of potential donors from Canada, I overheard a physician tell the nurse who was guiding the group on their visit, "Don't be afraid to show them your bellybutton," in other words, the hospital's vulnerabilities and weaknesses. In this case, "bellybuttons" might include empty medicine cabinets, overcrowded hospital wards, and lack of basic infrastructure. All of these could act as proof that aid was truly needed, and that the hospital was a worthy recipient. Because potential donors may turn away from potential recipients who already have resources (particularly from external donors), those soliciting aid have an interest in concealing resources, or at least, keeping them discrete. A nurse told me that she believed that hospital administrators were letting one specific ward fall into a terrible state of decline with the hopes that an organization would be appalled by its condition, tear it down and rebuild it.

These dynamics were particularly visible at the HUJ's ophthalmology department, which was renovated shortly before I began my research. Directed by a charismatic young physician who had completed her residency at the hospital and pursued training in France, the department had received 160,000 USD from

four international organizations to renovate its small building and purchase equipment and supplies. A comment which I often heard from visitors to the HUJ was, "Ophthalmology doesn't look like the rest of the hospital!" Not only was it clean, brightly painted, furnished with new equipment and decorated with Haitian art, but the department had its own generator and small operating room, which granted it significant autonomy vis-à-vis the hospital's central structure and administration. The department attracted patients from throughout northern Haiti, and was able to provide surgeries for cataracts, glaucoma, and other pathologies. The director, although visibly proud of her department's success, lamented that since its renovation, foreign visitors would take a quick look at ophthalmology, compliment the service and proclaim that it didn't need their help, and move on to another section of the hospital. This was confirmed by several foreign volunteers and aid workers who told me that ophthalmology was not a priority for their organizations because of how well it was doing. Meanwhile, the department's staff hoped to attract new donors and to increase support from existing benefactors, as the number of patients seeking services had increased dramatically since the renovations. The department had also undertaken an ambitious project of screenings and mobile clinics in rural areas around Cap-Haïtien. The department's staff worried that their success might lead to their downfall, as new sources of support would probably continue to bypass them as long as their success was apparent. After hearing many narratives about the origins of diverse medical aid projects, which often involved an encounter with a crumbling clinic, an area void of medical services, or high rates of pathologies, it became clear to

me that the solicitors and administrators of aid have good reason to avoid displaying their resources and strengths.

Paradoxically, pressures to hide existing wealth and resources are countered by incentives to do just the opposite: to display one's credentials as a dependable recipient of outside support, as one who has been entrusted in the past, and who is able to correctly manage future resources.[45] As much as donors seek out impoverished, needy and neglected recipients, they are also eager to find beneficiaries who are credible, deserving, and, particularly in cases where aid is to be redistributed, able to allocate resources fairly and transparently. Haitian health professionals, who are often soliciting international aid on behalf of patients, are therefore obliged to present both pressing needs and evidence of success in helping to address those needs. A particularly compelling strategy for achieving this balance is to recount or display instances in which previous support was discontinued or re-directed, despite successes during the time of support. I often saw Haitian health professionals show foreign visitors buildings that fell into neglect, equipment that broke down, and empty pharmacies, all framed as evidence of prior support that was discontinued or had moved elsewhere. Not only do such displays highlight a current lack of support alongside evidence of pre-existing capacities to absorb and redistribute aid, they can also be used to critique abandonment by prior supporters. It is all too easy to find evidence of

[45] In addition to influencing relationships with foreign donors, personal appearances and displays of resources also play an important role in self-presentation among Haitians. Dress, language, demeanor, and access to visible resources such as vehicles or exclusive spaces are all used to send convey messages about status, worth, and social position. Many of my foreign informants often expressed surprise at the elegance and neatness of Haitians' dress, assuming that high standards for personal appearance in an impoverished country would be inexistent or impossible to achieve.

discontinued, failed and abandoned interventions in health establishments and other domains throughout Haiti, which I have heard described as a "graveyard of projects." Finally, visible affiliations with benefactors are also a source of prestige and status for Haitian recipients, who can use these relationships to earn admiration and respect.

Just as potential recipients have incentives to both hide and display the existence, provenance, and amount of resources so they receive, donors are also caught between contradictory pressures to make their interventions visible and obvious and to conceal them and distribute in secrecy. The rewards of executing a very visible aid intervention are numerous. If the implementer of the intervention (whether foreign or Haitian) has received funds from another source, a public intervention will help protect the implementer from accusations of corruption or diverting funds. Elizabeth MacAlister has described how aid in Haiti often operates in "the unseen world of hidden, covert, and sometimes illegal political and economic deals between both Haitians and Americans (and others) that have been instrumental in shaping the overlapping crises that Haitians confront (McAlister, 2010)." Resources that are visibly distributed are more easily accounted for, and given the amount of aid funding and resources whose trajectories are not seen by the general public in Haiti or donor countries, a visible distribution is often a notable and remarkable event. Visible distributions of resources often occur in the context of public ceremonies, and are generally accompanied by speeches of gratitude and optimism, such as the one I described in Chapter 2. Even when distributions are not completely public, photographs are

often used to increase the visibility of disbursement: the classic aid photograph shows donors and receivers smiling with the transferred resources: proof that they have indeed arrived.


Figure 4.2 An American aid volunteer poses with Haitian colleagues in front of donated supplies at the Port-au-Prince Airport shortly after the January 2010 earthquake. Photo: unknown. http://www.foyerdesion.org/images/MAF_Foyer2.jpg

Figure 4.3 The Haitian physician in the foreground of this image asked me to photograph her as she distributed the safe birthing kits donated by a group of Americans. The photograph would assure the donors that that their contributions were received by the intended beneficiaries. April 2009. Photograph by the author

A visible intervention may also prevent another actor from appropriating (or being credited by others for) the act. During my fieldwork, there were several occasions in which individuals and foreign non-governmental organizations were strongly encouraged by Haitian partners to put their names and logos on material and infrastructure projects such as buildings, furnishings, and waste receptacles. In addition to deterring outright theft in the case of mobile objects, donors were told that if their own identifying marker didn't appear on the resource, people might think that the Haitian state had provided it. A stenciled name or logo would serve not only as a means for the donor to accumulate credit (which I will discuss

in the following chapter) but also as a reminder to the population that the state was delinquent in its obligation to provide basic services. While foreign groups operating in Haiti are often accused of "planting their flags" for self-serving reasons (and I concur that these accusations are often well-founded), I did observe cases in which it was the recipients, rather than the donors, who insisted that the latter's name appear on an intervention, for the reasons listed above.

There are pitfalls, however, when donors make their interventions visible, and some prefer to act in secrecy, complicating efforts at coordination. An important factor is the incapacity to respond positively to the numerous solicitations that a public distribution generally entails. The solicitations may be immediate, as in the case of a vitamin distribution or blood pressure screening that attracts large crowds. In these cases, there may be a great deal of excitement and fervor among the population hoping to access the resources, and while I have witnessed many such interventions take place harmoniously and without disruptions, being turned away because resources have run out can lead crowds to become unruly. Haitian health professionals and those foreigners with more experience in the country were often cautious about scheduling a public distribution unless they were certain that their supplies would meet the demand. In some cases, security precautions were taken, including hiring men to act as security guards and restricting access to a distribution site by letting people through a barrier in small groups.[46]

[46] This issue became a central concern in the distribution of food and other resources after the January 2010 earthquake. Donors developed various strategies to avoid chaos or violence during distributions, such as issuing tokens or cards prior to the distribution, or by only allowing women to claim resources or behalf of their families. While media reports focused on incidents of post-

In other cases, the solicitations that followed a visible intervention or distribution were not immediate, but were made at a later date. In the case of short-term visiting clinical teams, for example, the first two or three days of a week-long mission tended to be quieter, but as word spread in the surrounding areas that foreign health workers were in the area, the number of patients grew, and on the final day, large crowds of hopeful patients had gathered near the site. (These trends were sometimes mitigated by local partners who began announcing the group's impending arrival in the weeks that preceded it, and in some cases distributed or sold cards that granted access to a consultation with the foreign team). On a smaller scale, individual group leaders described increases in individual solicitations after a visible intervention: individuals or representatives from groups would appear at their hotels or guesthouses, often with a formal, written request for assistance. After the inauguration of the pediatrics emergency room was broadcast on Cap-Haïtien's radio station, Nate Nickerson anticipated that Konbit Sante would be heavily solicited because the group's name was featured prominently in the inauguration and subsequent radio reports. Nickerson told me that he found turning down solicitations and requests to be one of the most difficult dimensions of his work in Haiti – this sentiment was echoed by many foreign aid workers and volunteers. They stressed that they consider the majority of requests to be reasonable (assistance for a school, medical supplies, food, housing or basic infrastructure), and turning them down was therefore particularly discomfiting. As visible distributions tend to increase the number of

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quake violence and looting, reports from colleagues and friends in the area suggest that most distributions were peaceful and orderly.

subsequent solicitations, donors often preferred to keep their interventions discrete.

In short, understanding the coordination and lack of coordination of international medical aid in Haiti requires an awareness of the diverse and sometimes contradictory incentives participants in the aid process have to either make their actions and relationships publicly known, strategically visible to specific parties, or as concealed as possible. While most of my examples involve individuals and relatively small groups working in a very specific context, the pressures I have described above also exist on a larger scale, and can provide insights into the medical aid process in Haiti more broadly, as well as in other settings where the transfer of resources occurs in a context of great scarcity.

### 4.3 Dumping

In addition to the incentives that decrease the coordination of activities and interventions among the participants in international medical aid, there are other patterns and practices that have become naturalized as part of the aid process, and that are both the results and causes of a lack of coordination. I have grouped these practices under the umbrella term "dumping," which is often used in formal economic terms to refer to predatory or heavily subsidized pricing. In the Haitian context, the term can be used to describe the influx of foreign commodities including food, used clothing and housewares, medications, and other items that have flooded even the most rural markets in recent decades. Dumping has been identified as a contributing factor of food scarcity in Haiti,

where local agriculture has been undermined by the arrival of cheap, heavily subsidized foreign foodstuffs. The most-cited example in this sphere is that of rice, which is imported to Haiti from the United States, undercutting Haitian farmers and making the country's population vulnerable to fluctuations in price and food insecurity (Oxfam, 2005). Other examples include second-hand clothing and shoes, which have reduced the demand for locally-crafted apparel, motor vehicles and bicycles, which arrive to Haiti in varying states of disrepair, and housewares such as bedding, dishes and furniture. Medicine and medical equipment also make their way to Haiti from other countries: in addition to the importation of pharmaceutical and medical products (primarily from India, Latin America, and China), medical goods also arrive in the form of donations from governments, NGOs and pharmaceutical companies. These may be new, used, expired, or ambiguous in their condition and origin. As donations, they can be brought by the members of a group during their intervention, or expedited by an overseas organizations or agency to a Haitian or expatriate recipient.

There are two critiques inherent in the term dumping: one that concerns the value or quality of the items in question, and one related to the means in which they are transferred. In the Haitian context, it is clear that many of the items which enter the country are of low or poor quality. White rice and flour offer little nutritional value, used clothes are often torn or stained (making them difficult to resell), and equipment and machinery are often antiquated or barely functional. While these items are used throughout Haiti, and may have redeeming or appealing qualities (a market vendor once excitedly described to me how she

had found four US dollars in the pocket of a donated shirt), they also represent Haiti's lack of local production and dependence on foreign nations for even the most basic of goods. In addition, even in the case of "free" donations or desirable items, their arrival and presence often creates tense or potentially conflictual situations that recipients and administrators need to *jere,* or manage.

The second critique inherent in the term "dumping" lies in the way in which the item is transferred, that is to say, carelessly and indiscriminately. Dumping happens with little regard for when or where the item arrives, who benefits from (or is harmed by) it, or what its ultimate fate is. In the case of dumped aid, the items may arrive unannounced, or at a time when they are not needed, or when the labor or space needed to process or store the items are unavailable. The dumped items may have been sent to an inappropriate location, either in terms of local needs or inhospitable conditions. They may be targeted for a specific population that is not present at the site of delivery. Finally, dumped items are rarely followed-up on: the sender is not likely to make inquiries into their fate or address any of the issues or concerns that ensue from the dumping.

A case of dumping at the HUJ will illustrate some of the points above. In the fall of 2008, a large shipping container of clothing, packaged food, medical supplies and equipment arrived at the hospital. The container was sent by a foundation established by an American nurse, who named the foundation after herself, and appeared to be the only person involved in the organizations. For the past five years, the nurse, who I will call Susan Miller, had been collecting

donations to ship to countries in Africa, Asia and Latin America. She had been moved to send the container to Haiti after seeing news reports of Haitians consuming mud "pies."[47] This container was the first she had sent to Haiti, and she traveled to Cap-Haïtien to be present for its arrival and unloading. When I met her in the hospital's courtyard, standing next to the container, she was extremely flustered and agitated. After asking about my presence and activities at the hospital, she asked if I would translate to facilitate her communication with the hospital administration. "Finally, someone who speaks English!" she exclaimed. She told me that she had been in touch with the hospital's administration by email, and that they were aware of her and the container's arrival, although this was refuted by the hospital staff I spoke with. Susan's main concern was to quickly get the container unloaded and distribute its contents. Her demeanor with the hospital staff was authoritative and impatient; she whispered to me that she suspected that they were planning on stealing its contents: "There's a lot of corruption here!" she said. Meanwhile, the hospital administrators scrambled to find workers to unload the container, and find a space to store the donations. Their dismay with the situation was evident, and as I saw what was in the bags and boxes that began emerging, I could see why. The donations consisted of bags of wrinkled, used clothing, some of which appeared to be stained and torn; crumpled boxes of various medications and medical supplies,

[47] Coverage of Haitians eating cakes made of clay (usually referred to as "mud"), which may also contain margarine and salt, appear from time to time in North American media. These reports often neglect to mention that Haitians, like other populations, have long consumed clay for its medicinal properties. The sensationalized reports often do not describe the clay's source, preparation, or dosage among who consume it, and while the cakes' preparation and sale may indeed be related to widespread hunger and malnutrition in Haiti, these reports also perpetuate a legacy of portrayals of poor people of color as less than human, as evidenced by their consumption of non-food substances (Sites, 2006; AP, 2008)

very little of it in intact packaging; and cases of sugary snacks and candies. There were several large bags of used stuffed animal toys, including an enormous purple Barney the Dinosaur doll, which Susan claimed would be perfect for the pediatrics department. Finally, the shipment also included an antiquated colonoscope, which Susan warned was extremely fragile and valuable.

I spent much of the day with senior hospital administrators as they negotiated with Susan and attempted to find ways to deal with this large and unexpected donation. Their dilemma was representative of those experienced by many Haitians who act as nodes in international interventions. While Susan pushed for an immediate distribution of the clothes and food, the administrators feared that such an activity would attract a large number of hopeful recipients, and the hospital was already extremely crowded during ordinary periods of operation. Given the poor quality of the clothing, potential recipients might accuse them of having taken the best items for themselves. However, if they chose to discard the donations or direct them elsewhere, both the donor and the local population would be likely to accuse them of corruption, favoritism, waste, or irresponsibility. Their solution to the dilemma was to store the items in order to liberate and send away the shipping container, thereby placating Susan by demonstrating that the donations would be cared for, and ultimately postponing the decision about how to distribute the items. After deciding that much of the material could be stored in a covered stairwell (securing space, whether it be for clinical care, administrative work and storage was one of the hospital's main challenges), two hospital porters began unloading the donations. As they became aware of what kinds of goods

they had received, the hospital administrators became increasingly frustrated. Most of the clothing was deemed useless, the medical products appeared to them to be of dubious quality, and would demand a great deal of time and energy to sort through, and the colonoscope faced an uncertain future, as there was no personnel trained in colonoscopy techniques employed at the HUJ. (They also determined that Barney, with his imposing stature and gaping jaws, was likely to provoke more terror than comfort among the hospital's pediatric patients.) All of these assessments and the emotions which they provoked were hidden from Susan, who dashed back and forth between the container and the storage room to make sure that the process was going smoothly. The hospital staff also maintained hope that more useful items would appear from the depths of the container, but when I spoke to them the following day, their assessment was that this particular donation had caused much more trouble than it was worth.

The critiques of dumping are quite different from another common critique of aid: that the materials or resources sent are insufficient. Informants frequently echoed the following statement from a HUJ employee: "The little they do give you gets used up very quickly. It's as if they never give you enough to get you standing on your own two feet." Rather, in dumping, the primary critiques are not about the aid's insufficiency, but involve the poor quality of the items and the donor's lack of regard or consideration about the recipient of the aid, and the ensuing life of the gift and the consequences it may have on others. As one resident told me: "the people who give are satisfied to just give, but they don't really have oversight over what they've given." The case of expired

medications in illustrative: in the past five years, MSPP has become stricter about its policy that expired medications should not be allowed into the country. Working with customs officials and law enforcement agencies, this initiative has led to a greater number of incoming pharmaceuticals being confiscated and destroyed. Similarly, the HUJ's administration has implemented a policy of discarding medications from its depot which have reached their expiration dates, but must be careful about doing so, given that public knowledge of medicine being incinerated could bring about outrage in the local population. In such situations, it might be much easier for Haitian administrators and health personnel if the expired (or nearly expired) medications had not been sent in the first place, although donations of medicine from abroad represent an important weapon in the fight against morbidity and mortality in Haiti.

While much of the critique related to aid, coordination and dumping expressed by Haitian informants was directed at international organizations, agencies and governments, many also expressed critical perspective about their own and their colleagues' role in receiving and administering aid. For example, a Haitian physician told me, "The people who receive aid distribute it poorly, they use it poorly… We have things that are rotting in the depot, and when you prescribe medicine for a patient, they don't have money to buy it. They [the hospital administrators] only give out the medicine when it's expired." Almost invariably, critiques of foreigners' thoughtless and nefarious dumping practices were tied to the Haitian state's inability or unwillingness to control or prevent such practices. While Haitians have grown accustomed to their state's

weaknesses and failures, they continue to assert that the state should assume its roles and responsbilities. Primary among these was the coordination of international actors in the country.

### 4.4 Coordination and the Haitian State

Within the Haitian government, there are two ministries that have a mandate to coordinate international medical aid: MSPP (the Ministry of Public Health and Population) and MPCE (the Ministry of Planning and External Cooperation). Foreign NGOs operating in Haiti are legally required to receive official status from the MPCE and those working in the health sector must obtain approval from the MSPP to conduct their activities. I encountered groups who had been waiting for two years to hear back from the ministries after having submitted their applications and forms. Many groups begin or continue their operations during this limbo period, and others, having witnessed other organizations' failure to receive a response to their applications, never initiate the registration process in the first place.

Like other ministries, the MPCE's and the MSPP's extreme centralization in Port-au-Prince means that local branch offices and representatives have little authority or resources. While the northern branch office of MSPP in Cap-Haïtien held meetings, seminars, and trainings for the employees of public health establishments throughout the department, to my knowledge, it never brought together the various international groups and agencies active in the region the way the Cap Haitien Health Network has attempted to. For many of the groups that

operate in Cap-Haïtien and other parts of northern Haiti, Port-au-Prince is simply a transit point between a foreign destination and their site of intervention in Haiti. In recent years, many groups have avoided the capital altogether because of criminality (both real and imagined) and the expense of lodging in the capital. This, combined with the limited capacity of departmental ministry offices to make executive decisions or grant authorizations, means that many foreign organizations can and do avoid interacting with state structures as much as possible.

Considering the Haitian government's potential role in coordinating aid raises a number of complex issues. As mentioned previously, while Haiti has been governed by democratically-elected governments for fourteen of the past sixteen years, its long legacy of dictatorships, coup d'états and instability bring into relief the risks of relying on a fragile or "predatory" state (Fatton, 2002). These risks have increased with the uncertainty that accompanies the end of René Préval's second presidential term in the spring of 2011 and the end of a 20-year period of Aristide-Préval leadership. In addition, coordination can very easily lead to centralization, as well as the concentration of resources and authority, which is frequently named as one of Haiti's major social and political problems. (The perils of centralization have been dramatically illustrated by the impact the 2010 earthquake has had on the country as a whole in terms of governance, economy, and political instability.) Examples of centralized resources and procedures abound: the administrators at the HUJ (and at any public establishment throughout the country) cannot hire, promote or fire any of their

personnel at any level without the written approval of the Minister of Health in Port-au-Prince. International aid (particularly that which is independently and locally managed and negotiated) offers a wide variety of resources and possibilities that are unavailable through the state. In many instances, it's evident why coordination and centralization would often be less appealing than autonomy and flexibility.

The relationships between non-governmental actors, foreign governments and the Haitian state can be considered in terms of sovereignty. Pandolfi (2002) has developed the term "mobile sovereignties" to describe NGOs and international organizations that, through their actions and operations, "impose institutions and concepts of citizenship that are alien to territories in which the nation-state has never established its power (Pandolfi, 2002: 34)." In order to do so, these groups use a wide range of means, but rely on existing structures of power. The moving sovereignties constitute "a network of governance characterized by innovative strategies of de- or re-territorialization (35)." Pandolfi situates her analysis within Foucauldian notions of biopower, as well as Agamben's theorizing on legitimate power and the state of exception. She devotes particularly attention to what she refers to as the "humanitarian apparatus," which acts on three levels: the right to intervene, the temporality of emergency, and the imperative to act. Humanitarian work, Pandolfi argues, is fundamentally homogenizing, creating interchangeable categories such as "the trafficked woman" or "the refugee child." Pandolfi's framework cannot be applied to Haiti in blanket terms: growing partnerships between NGOs and the

Haitian state, example, complicate the discretion of these two categories. A temporality of emergency applies to Haiti inasmuch as the emergency (or crisis) is constant, and therefore, absent, as these two terms inherently involve evanescent conditions. The coordination of international interventions there, however, does require the control of a truly sovereign entity, one which does not currently exist and is unlikely to emerge under the current configurations of power. The mobility described by Pandolfi, as well as the levels of action of humanitarian apparatus, are certainly relevant to the Haitian case. In addition to the presence of hundreds of NGOs working in various sectors throughout the country, Haiti is also host to MINUSTAH, the UN Mission for the Stabilization of Haiti. Present since Jean-Bertrand Aristide's ouster in 2004, the multinational force is comprised of soldiers and officers from various countries, with strong representations of Latin American and Asian contigents. During my research in Cap-Haïtien, I spoke with Haitians who were both grateful for the stability that came with the presence of an armed force, and others who resented what for them represented a military occupation. This latter group has certainly grown in the context of recent events, namely the 2010 cholera outbreak (attributed to Nepalese soldiers posted in the Central Plateau) and stagnant or worsening socio-economic conditions.

The enormous influx of international aid that has entered Haiti in the aftermath of the January 2010 earthquake compounded with the damage to Haitian state infrastructures and the uncertainty related to the upcoming change in government portend that the issue of coordination will continue to be a major preoccupation for participants and observers of the international aid process. If

the various parties who have called for increased coordination are sincere in their stated desires, they will have to take into consideration their own and others' motivations and incentives for not coordinating, and serious attempts to mitigate their negative effects.

## Chapter 5 Moral Economy, Resentment and *Ressentiment*

In the preceding chapters, I have described some of the diverse exchanges related to international medical aid in northern Haiti, and analyzed some of the diverse and conflicting perspectives, opinions and emotions expressed by the various stakeholders involved in this aid. While some of Haiti's particular characteristics (its geographic location, historical context, and situation in various political economies), and the nature of ethnographic fieldwork bring out the specificities of the processes and relations I studied, my intention in carrying out this research has been to develop analyses that have relevance beyond the realm of medical aid, and beyond the case of Haiti. I am particularly reticent to contribute to a long legacy of what Trouillot (1990) calls "Haitian exceptionalism." Usually described in extremes for its poverty, its dismal health indicators, and its turbulent and dysfunctional politics, Haiti is most often used as an example of the exceptional and anomalous rather than a site from which to draw conclusions about social relations, interpersonal dynamics and morality on a larger scale. To do so, I will draw from two bodies of literature: texts on moral economy, and writings on resentment and *ressentiment*. These frameworks can be used to investigate and interpret some of the exchanges and emotions I observed during my fieldwork; conversely, my data can be used to refine and interrogate some of the assumptions, claims and prior applications associated with theories of exchange, emotion and morality.

### 5.1 Moral Economy as Described by Didier Fassin

In a paper entitled "Moral Economies Revisited," French medical anthropologist Didier Fassin (2009) traces the origin of the concept and discusses its continued use by social scientists, particularly by anthropologists. Fassin's text is a useful starting point for my discussion, as it provides historical and intellectual context for the concept, as well as directions for its future applications in anthropology. Fassin's genealogy of moral economies is as follows: first coined by historian E.P. Thompson to describe the behaviors of the English masses in reaction to rising grain prices, the term was only defined by the author eight years after its first use: "a consistent traditional view of social norms and obligations, of the proper economic functions of several parties within the community, which, taken together, can be said to constitute the moral economy of the poor" (Thompson 1963; 1971: 79). Fassin discusses Thompson's ambivalence toward the concept he created, citing a text from 1991 in which he conceded that he could have used the term "social economy" or "political economy," and that he wished to stress the classical Greek meaning of the term *oikos*, related to a household in which "in which each part is related to the whole and each member acknowledges her/his several *duties and obligations*." (Thompson, 1991: 271) In Fassin's analysis, Thompson's affirmation – "that the poor also have characteristics and logics that orient them in their evaluation of what is good and what is just, and on which they rely to act in the world" – would have an explicit influence on the work of political scientist James Scott (and the anthropologists subsequently influenced by Scott's writings). Lorraine Daston,

however, used the term in a very different sense in her work in the area of science and technology studies, and although Fassin says although subsequent work in this field would "rediscover" moral economy's Thompsonian legacy, he does not provide specific examples.

Fassin lists a number of works that use the concept of moral economy, selecting a variety of diverse topics that testify to how many authors seize or appropriate (*se saisissent de)* the term without justifying its use, to describe "a number of social realities in which it happens sometimes that neither economy nor morality appear clearly (1239, my translation)." Fassin mentions his own work on poverty, immigration and violence as a motivation for his clarification and "theoretical renewal" of the term. He begins this process by analyzing Thompson's, Scott's and Daston's use of moral economies in their respective works.

According to Fassin, Thompson endeavored to bring a qualitative, ethnographic approach to the study of the English working class, one which would consider its members lived experiences and the processes of its subjectivization. This process would do for the "poor" what anthropologists had done for the "primitive": recognize the existence of norms, rights and obligations in their midst. Based on Thompson, Fassin identifies two levels of analysis that most commentators don't dissociate: a system of exchange of goods and services and a system of norms and obligations. In Fassin's reading, moral economy according to Thompson "corresponds" to these systems, or "integrates a double dimension." These dimensions cannot be dissociated because their confrontation

only takes place when the moral contract binding the parties ruptures. Fassin suggests that Thompson is more concerned with mores rather than moralities, as are, he claims, most anthropologists.

Fassin then discusses moral economy in the work of James Scott (1976), whom he claims was responsible for importing the term into anthropology and promoting its use in the study of subaltern (particularly peasant) populations. Fassin expresses some ambivalence regarding Thompson's direct influence on Scott. He states that "[Thompson's] influence seems rather limited aside from its use in the book's title," while in the same sentence claiming that Scott's work adheres explicitly to the trajectory of Thompson's work. Scott's two major modifications of the moral economy concept, according to Fassin, involve the attention paid to everyday forms of peasant resistance (rather than to open rebellion or revolution exclusively) and the centrality of values, particularly the sentiment of justice, to moral economy. This expands the scope of the concept beyond the realm of norms and obligations. Fassin argues that Scott's (and his successors') usage can also be characterized by additional attributes: it implies the existence of pre-market economies and a confrontation with liberal economic pressures, and mainly involves dominated populations.

Finally, Fassin addresses the work of Lorraine Daston, a historian working in the field of science studies, who he suspects came upon Thompson's work only after her article "The Moral Economy of Science" was completed. Daston's definition, "a web of affect-saturated values that stand and function in well-defined relationship to one another (Daston, 1995: 4)." Describing her analyses of

quantification, empiricism and objectivity, Fassin claims that Daston's use of moral economy has two notable characteristics: it considers economy in terms of configurations of regularities and rules, and also expands the scope of moral economies to include all of a society's strata, not only its dominated and subaltern segments. Fassin applauds this expansion, but is concerned about the fate of the concept's political dimensions and critical perspectives on social relations in their unjust and violent forms.

Finally, Fassin turns to his own use of the term. After describing the uncertainty over which of the concept's two components to emphasize (*moral* economies or moral *economies*), Fassin proposes his own definition, which he bases largely on Say's early 19th century definition of political economy: "the production, distribution, circulation and utilization of moral sentiments, emotions and values, norms, and obligations in the social realm." Fassin specifies that this usage highlights "moral" over "economy," brings together norms, values and emotions, and can be applied to society as a whole and all social worlds. Using examples from his research on immigration, asylum, and marginalization, Fassin argues that using a moral economy approach can counter the tendency of political economy to delegitimize actors' subjectivities by providing an emic perspective on and recognition of political subjectivity. Moral economies also provide an alternative to static models of culture that assume stability and heterogeneity. His assessment of the term's validity and potential is summarized by the following:

> "Fundamentally, we must judge the potential of moral economies on their capacity to produce new forms of intelligibility of the world. Where moral philosophy and moral sociology tend to think in terms of facts or moral dilemmas (and in so doing individualize positions and formalize oppositions), the anthropology of moral economies favors stakes and moral conflicts, their

> historical trajectory and political dimensions. It is less interested in the moral as such as in what the confrontations it raises tell us about the societies we study (1265)."

Despite his opening remarks that suggested that the term was overused to the point of banalization, Fassin argues for "a concept in becoming," particularly in ways that continue to expand its usage beyond dominated groups, and that maintain a critical perspective, namely by being attentive to "the tensions and conflicts between different moral economies to analyze their stakes." In many ways, my own research responds to Fassin's call; while my analysis highlights different dimensions of moral and economic exchanges, I am particularly interested in examining the tensions and conflicts (and convergences) between distinct moral economies.

### 5.2 Thinking Through Moral Economies

Because negotiations related to morality and economics in diverse forms were such an evident dimension of the international aid interventions I studied, the moral economy concept has the potential to contribute significantly to my analysis. As an anthropologist, my goal here is both to use the concept hermeneutically as a means of gaining deeper understanding of specific ethnographic data, and to contribute to the development of the concept more broadly, increasing its relevance for the study of exchanges and interactions, particularly in the context of various kinds of inequalities. For the purposes of this essay, I will define a moral economy as a system of exchanges and calculations that are governed by notions of right, wrong, good and evil. Exchanges in moral economies do not necessarily adhere to the rules of capitalist

or cash economies, or even to pre-capitalist economies based on barter or gift-giving. Unlike Fassin, I am including the exchanges of material goods, capital, labor and other resources in my analysis, given their importance in settings such as Haiti, where many of the sentiments, norms, and values exchange directly concern more tangible resources.

An initial question raised by the concept of moral economy is the choice to use the term in its plural form. Fassin's use of the plural appears to correspond to his assessment of the various uses of the term the term by scholars, as his own definition (1257) retains the singular. It is tempting to consider the many moral economies present in a given situation as a way of highlighting the diverse and often contradictory perspectives and influences actors may have. For example, a Canadian nurse may have emotions, values, obligations and practices that are distinct from that of a Haitian physician, even though they two individuals are involved in the same aid intervention. To return to the classical definition of economy, which involves the management of household resources and roles, actors involved in international aid have sometimes overlapping but often distinct strategies for managing resource allocation and procurement – the same is true for their values and obligations. Should each individual, then, in Haiti and elsewhere, be attributed his or her own economy? How, then to account for the systemic and shared dimensions of these multiple economies?

This question can be resolved by applying another term. Early economic anthropologists developed the term "spheres of exchange" to describe how objects that were considered incommensurable could be exchanged within different

spheres in a single society. While early examples (Bohannan and Bohannan, 1968) involved the examples such as the impossibility of exchanging yams (a food staple) for cooking pots (metal implements), a moral economy of international medical aid can be thought of in terms of the spheres of exchange it encompasses, specifically in regards to the many transfers, exchanges and gifts that take place outside of (but overlapping with) more tangible commodities. In the context of international medical aid, for example, a sphere of exchange that includes tangible goods and services such as donated pharmaceuticals and free surgeries overlaps with other spheres in which sentiments such as gratitude and resentment circulate. As stated earlier, exchanges are central to the international medical aid process in Haiti, and exchanges of more tangible resources such as funds, medications, equipment, medical professionals and clinical services are closely related to more intangible exchanges involving emotions, values, status, norms, and obligations. In my research, I have found that the tangible and intangible exchanges in aid are tightly interwoven, as most of the sentiments expressed and experienced about the aid process by those involved in it are specifically *about* the movement of very concrete goods and services. In the two examples that follow, I will illustrate how the concept of moral economy reveals some of the more subtle aspects of international medical aid in Haiti. Specifically, I will propose three components of a moral economy to further my analysis.

**Interest, Credit and Debt**

The first phenomenon I will address using a moral economy framework is the provision of health services by foreign clinicians. The advantage of the framework is immediately apparent in that it allows for recognition of actors beyond the simple donor-recipient dyad, and also allows for heterogeneity among various categories. For example, most of the North Americans physicians whom I encountered providing health care in Haiti were older individuals who lived in relatively wealthy communities and enjoyed a high standard of living. Many worked in Haiti without any financial remuneration, and paid for their transportation and lodging during their one to two week stays. Cuban physicians are also found throughout Haiti, however, these doctors work in Haiti for two-year periods. In Haiti, Cuban physicians receive free housing and a monthly stipend of 300$ USD that dwarfs their regular Cuban salary of approximately 25$ USD per month. Working as an international doctor can also improve working conditions upon returning to Cuba, particularly in regards to assignment in urban areas, which are considered more desirable in terms of their proximity to various resources and opportunities. Finally, missions to countries such as Haiti allows for the opportunity to purchase household appliances such as stoves, refrigerators and computers. Both Cuban and North American physicians are participants in a moral economy of medical aid, and in additional to interpreting their exchanges in moral terms, are also evaluated by others. These physicians' participation in the aid process, however, reflects much more than their own motivations and intentions, but also testifies to historically-specific geopolitical, economic and biopolitical configurations that frame their work and its consequences.

The second phenomenon is one which I discussed extensively in the previous chapter, that is, the emigration of qualified medical staff. This emigration has a significant impact on the health of the Haitian population, which does not have an adequate health labor force to meet its basic health needs. As I mentioned, only two of the fifty-two Haitian medical residents I interviewed at the HUJ intended to remain in Haiti after completing their residencies, with the vast majority hoping to pursue training and careers in the United States, Canada and Europe. I discussed some of the factors fueling their desire to emigrate: higher salaries and access to increased resources for themselves and their families, working conditions and instability in Haiti, and the desire for greater learning opportunities and professional advancement. I also discussed the various international programs that work to retain Haitian health professionals in Haiti, whether through scholarships abroad that contractually obligate medical school graduates to return to Haiti, or higher pay offered by NGOs in private establishments (or occasionally in public institutions, like in the case of Konbit Sante's salary supplements at the HUJ). In addition to the political economic dimensions of Haitian doctors' emigration, this phenomenon (and the international aid initiatives that attempt to counter it), can also be examined using the concept of moral economy.

Using the two examples above, we can apply three components of a moral economy analysis (interest, credit and debt) in order to analyze some of the less obvious dimensions of international medical aid in Haiti.

The term interest has multiple meanings. In conventional economic terms, it refers to the fee paid for borrowed assets. It can also refer to a benefit or advantage, a stake or a share, or a curiosity for or attention to. All of these dimensions of the term were present in my informants' discussions of international aid. Haitian informants regularly complained about *enterè pèsònèl*, or "personal interests" or stakes that caused resources to be squandered and aid programs to fail. They claimed that the country's well-being was compromised by these personal interests. More than motivation, the notion of interest implies the stakes related to a prior investment. I did not hear people speak of "general interest" as the opposite of "personal interest," rather; the term "*dezenterese*" (disinterested) was used to describe aid that was given without any thoughts of personal gain or advancement. The most disinterested aid was given to complete strangers, as the most obvious interests to be nourished through aid and gifts were interpersonal relationships and the opportunities they offered for reciprocal exchanges. Questions about foreigners' interests in carrying out international medical aid abounded: "What do they get out of this?", "Some come because they really want to help, others are just here to make money," "I get more out of this than I give," – these are all statements that involve interests. Does a Cuban physician volunteer to work in Haiti in order to express solidarity with the population of a neighboring country, or in order to increase her changes of working in Havana upon returning to Cuba? What does a Canadian physician appreciate more: the gratitude expressed by patients in a rural Haitian village or the accolades and admiration he receives from his colleagues back home?

Interests, of course, can be multiple and sometimes contradictory. Actors in a moral economy negotiate their own interests as well as those of the individuals they interact with and observe.

Similarly, Haitian residents negotiated their own, their networks' and their country's interests in deciding whether or not to emigrate. Young Haitian clinicians and the international bodies that trained and hired them were aware of each others' interests, which often involved conflicting outcomes: staying in Haiti or migrating abroad. This is a dimension of the moral economy in which there is an enormous amount of speculation and conjecture by actors about others' interests, and significant energy spent on proving to others that one's interests are legitimate and noble.

The most obvious dimension of credit in the realm of international health interventions is the acknowledgement or recognition of one's deed by not only the recipient, but potentially by a larger audience. A donor agency's name painted on a building, a public ceremony to display thanks and gratitude, and public photographs on a website of donors carrying out interventions are all examples of how credit can be attributed. In the previous chapter, I wrote about some of the advantages and disadvantages associated with carrying out a visible aid intervention in Haiti—being acknowledged as the source of (in other words, getting credit for) an intervention can have unintended consequences. In addition, not receiving credit for one's work or deeds is also a source of acrimony. In the case of the Haitian medical residents, many expressed their frustration at not having their work valued or recognized, while foreign medical workers often

benefitted from visibility, recognition and access to resources.[48] Who gets credit for medical aid is often a contentious issue, as participants' roles are varied and the diverse resources they contribute are often not commensurable. Not getting credit for their work, effort or perceived sacrifices was frequently named by the HUJ's residents as a factor motivating their desire to emigrate.

Another dimension of credit is as a resource that can is not immediately disbursed, but can be stored and used for further action. People and organizations can earn credit through visible and successful projects that facilitate future interventions. For example, various groups' and governments' often justify their increased involvement in Haiti's health care system following the January 2010 earthquake by describing their presence and activities in the country *before* the quake. A sustained and long-term presence (particularly in a context where a large number of bodies were competing for attention and resources) is often used as credit: past actions and moral behavior make one a worthy recipient for continued and future trust. A Cuban writer described his country's contribution in these terms: "aid from Cuba to the people of Haiti did not come with the earthquake. Cuba has developed an Integrated Health Plan in Haiti since 1998, in which over 6000 Cuban health workers have participated (Manzaneda, 2010). In an online forum, a poster defended the legitimacy of "well-known and above-board organizations who were already active in Haiti long before the earthquake, so I think this is pretty solid (Sunnykerr, 2010)." It is common for groups to describe themselves (or be described by others) in terms of duration of

[48] Once again, the proverb "The donkey works but the horse gets the rewards" has particular relevance here.

involvement and scope of work accomplishment, both of which are means through which credit is accumulated to establish a position of moral reliability and solicit further support.

Finally, debt is a recurring theme in the moral economy of international medical aid to Haiti, and is framed in national, individual, and human terms. Economists and analysts often blame Haiti's financial debts to other nations and global financial institutions for the country's poverty. A series of recent debt cancellation measures by the Jubilee movements were hailed by many activists and analysts as an important step in improving economic conditions in Haiti, and a Haiti-specific debt relief measure was passed by the US Congress in 2011. The converse debts, framed in national terms, involve foreign nations' debts toward Haiti, specifically those directly involved in the country's history. These involve historical events with both specific material consequences and powerful symbolic valence. Foremost among them are France's debt toward Haiti for the enormous sum it extorted from the country's post-revolutionary government (as compensation for damage to French property), American debt to Haiti for the latter's assistance during the American Revolution,[49] as well as for wrongs committed during the American military occupation of 1915-1934 and other interventions, and by Latin American nations for Haiti's support for 19th-century independence movements and hospitality towards Simon Bolivar. The discourses related to these national debts vary enormously: President Aristide's vocal calls

[49] In the late 1700s, a force of over 500 "free men of color" from Saint-Domingue joined American forces in battles against the British in Savannah, Georgia. Largely forgotten by Americans, the event was recently commemorated with a monument statue in downtown Savannah.

for the restitution of the French debt became an issue of national debate; some argue that it contributed to France's role in his 2004 ouster. Other national debts appear during philosophical discussions among Haitians and foreigners, or in speeches that trace the historic ties between the two countries.

Debts are also framed in other terms, such as those of a shared humanity. Almost none of my informants, Haitian or foreign, described debts owed to Haiti based on exploitative labor practices such as factory assembly work by multinational companies. There were occasional mentions of debts owed by societies who had benefitted from the talent and labor of Haitian migrants, but these were not particularly emphasized. Rather, the language of debt often appeared in the theme of "giving back." For members of the Haitian diaspora, this formulation was relatively straightforward: they had benefited from the resources of their homeland, whether it be through tangible resources and opportunities or a sense of self, identity and national pride, and they wished to reciprocate using the skills and means they now possessed. This sentiment, however, had not developed among the hopeful migrants I interviewed at the HUJ. Rather than speak of their obligations toward Haiti and its population, it was much more common for them to identify the ways in which their country, and specifically its leaders and elite, had taken advantage of their youth and talents, and had exploited them without offering any promises of future rewards or benefits. They spoke of the population in more ambivalent terms: some stated that patients had no respect or gratitude for them (particularly as young doctors), while others stated that patients treated them with deference and affection. One

young physician told me that she wanted to stay in Haiti simply because the slightest gesture she made for her patients—a kind word, medical advice, or the most basic treatment—was met with such gratitude. While the young physicians at the HUJ do not currently interpret their clinical activities as a way of paying a debt, they may come to do so after emigration, as have many clinicians from the diaspora who return to Haiti as part of medical aid initiatives.

For foreigners, the debt or counter-gift was directed toward an unspecified recipient: they often used the term "giving back" to describe their activities. While the term itself implies a dyad, those who use it in this sense don't articulate that the resources they enjoy are not going "back" to their origins in any specific sense, rather it is a way of presenting their activities in a context of reciprocity. It also frames the donors' actions as the "right thing to do," rather than as an altruistic gesture stemming from individual initiative. I described this phenomenon in Chapter 2, and will simply add here that further questions about the phrase revealed that none of those who used it conceived of their work in Haiti as the direct repayment of a debt, but more as a redistribution of resources that they had received in excess. It was very rare to hear Haitian health professional frame foreigners' work in their country as the repayment of a debt.

The foreign aid workers and volunteers I encountered in Haiti identified a wide range of factors that compelled them to do this type of work: a desire to help others, an opportunity to travel and learn, a sentiment of attachment to Haiti or the Haitian population, and various kinds of rewards (emotional, financial, prestige, etc). It became clear during my research that motivations could be multiple and

even contradictory. Transactions in a finance economy can reflect many desires, serve multiple purposes, and defy single or reductionist explanations, and the same applies to transactions in a moral economy. Many of these transactions, however, are not made explicit by those who participate in them, while others' behaviors, actions and motivations are subject to speculation and conjecture by other participants. As recounted in Chapter 3, Haitian health professionals have explicit theories about foreigners' intentions and motivations in their country. Some of the theories involved involve altruism and generosity, while others reflected suspicions of inconsiderate or selfish motivations.

The three categories I have described above, in addition to having significance in more conventional economic terms, can also be studied as morally saturated concepts which exist as components of a moral economy. Thinking about these concepts and exchanges associated with them in terms of a moral economy draws attention to the collective and shared nature of efforts promoting and responses to phenomena such as international aid; both morality and economics always surpass individual and subjective experience to encompass broader networks, relations and societies, even if in doing so they engender clashes and conflicts of individuals' opinions.

Finally, the concept of moral economy is striking for its juxtaposition of two dimensions of human experience that are often considered distinct, and challenges commonly-held assumptions about the separation of moral and economic domains. Accepting that moralities and economies are closely intertwined, particularly in the realm of providing health services across social

and other disparities, sheds light on how diverse actors negotiate multiple and often conflicting values and pressures. A moral economy framework highlights the inseparability of these domains, and allows for analyses that are more nuanced and complex than exposés, specifically in considering the co-existence of multiple motivations and intentions, the various strategies and responses available to actors involved in the aid process, and the assignation of blame and culpability in cases of failed projects and undesirable results. Exposé accounts, as I have written earlier, are crucial in revealing the abuses, failures, and unintended consequences of international intervention. They are particularly necessary in light of the fact that contemporary international aid involves a wide array of actors and myriad processes that are not visible to the general public, and can have tremendously empowering or terribly devastating consequences on the lives of millions of people. They must, however, be supplemented with the types of analyses I have described above, a difficult task when one considers the popularity and appeal of exposé accounts. When I tell people in both settings, about the compensation that Cubans receive while working in Haiti, or about tax write-offs for donations by North Americans, people express an "A-ha!" of having identified an ulterior motivation and a self-interested dimension of the medical aid that taints or explains it. There seems to be a pleasure, almost a sense of relief, at not being duped, in not taking what appear to be generous or altruistic gestures at face value. In this vision, purely altruistic gestures are but illusions, and exposing them as such not only signals that one is astute and savvy, but can also protect one from the potential harm that could occur while under the illusion's spell. The

danger of exposé accounts, however, is that they tend to assume that greed and evil are necessarily the source of the problem. Anthropologists' contribution to the study of international medical aid and other health interventions is to highlight that people's choices and behaviors are governed by very pronounced and often conflicting notions of right and wrong. In a context where the stakes - health, livelihood and life - are so high, examining inequalities, resource distribution, and exchanges through the lens of moral economy offers possibilities for understanding how people maneuver in complex and often treacherous ethical landscapes.

**Resentment**

International medical aid in Haiti has contributed to better health, longer lives and increased opportunities for thousands of individuals. It is also a process that is fraught with conflict, tensions and ambivalence. Much of this can be understood in the context of unsatisfactory or fractured gift relations, which lead to resentment on the part of donors, providers and recipients. To begin, I will discuss the emotion of resentment as it is commonly understood in English: a feeling of anger or displeasure that results from a real or perceived wrong or injury. I will then turn to the concept of *ressentiment* as it appears in the writings of German philosophers Friedrich Nietzsche and Max Scheler, and discuss its applicability for the processes and relationships I observed.

Lisette Josephides, in an article entitled "Resentment as a Sense of Self," writes about supplementing her political economy analysis of social relations in

Papua New Guinea with an examination of "the placing oneself as a person within a value system, and the demand to be acknowledged as such by others, a desire or need to express oneself, to map out an area and construct a claim for oneself as a worthy person (Josephides, 2005: 72)" Describing resentment specifically, she states, "[I]t is not so much that resentment is the emotion that defines the structure of people's culture and identity, as that it is the mode of constructing the self everywhere; it is a manifestation of what Kant has described as respect for the self as the origin for respect for the law… (86)." While resentment is often regarded as a negative emotion, philosopher Marguerite La Caze argues that resentment, along with envy, enables people to "recognise and respond to injustices against ourselves and others and so relate to other human beings (La Caze, 2001:31)."

For the solicitor or recipient of international aid, there are many opportunities for resentment to build before, during, or after a gift relationship, or as the result of a gift's absence.[50] For example, an individual or group may be required to undertake onerous or time-consuming procedures in order to submit a request: this is particularly true when requesting aid donations from large organizations or agencies. Forms may be lengthy or difficult to understand, required documents may be unobtainable, and the point of submission may be inaccessible. For personalized requests, soliciting aid may involve various forms of humiliation, either self-inflicted (as part of a strategy to present oneself as a needy and therefore deserving recipient), or external, specifically by donors who intentionally or unintentionally cause the solicitor/recipient to feel ashamed or

[50] This framing of international aid as a type of gift is in no way intended to discount or minimize the explicitly economic dimensions of foreign aid; rather, it allows certain non-economic dimensions of aid to come into focus for analysis.

debased for making a request or requiring assistance. Resentment can also build among recipients of aid if a promised gift is delayed, particularly in cases where needs are urgent, and people have made plans based on the expected arrival of a donation at a specific moment.

Resentment can also be present during the actual giving of aid, whether it takes places over an extended period, or at a single, specific moment. It is often during the receipt of aid itself that recipients identify the substance, quantity and quality of the aid: I have often stood alongside Haitian recipients as they opened cartons of donations, sometimes delighted at the utility and value of the items, and at other times crestfallen, angry and frustrated that the gifts were not only useless, but could also represent an additional burden. In cases where donors are present, recipients may be pressured or obligated to express gratitude, which, I found during the course of my observations and interviews, is often heartfelt and sincere, but can also be formulaic and insincere.

After a gift has been given, recipients may experience resentment for many reasons. Donors may have certain expectations, either of gratitude or other affects, or expect certain logistical measures, such as accounting forms or reports, which can be burdensome or time-consuming. Recipients may themselves become donors if the gift was intended for redistribution, and this process can also lead to conflicts and stressors, some of which the original donors may not even be aware of. In addition, gift relations in Haiti often create expectations of sustained support. A common greeting, for example, is "*Ou lage m*," literally, "You've let me go." In addition to expressing affection and pleasure, the phrase is an

accusation of abandonment. I most often heard the phrase directed to men, who are expected to act as economic providers according to Haitian gender norms. It is very common as a greeting from a less powerful man to a more powerful one, and I often heard it directed at foreigners, not just by people who had received material aid, but who might have had social or visiting relationships. Ties with the powerful represent a potential resource in Haiti, and maintaining those ties is a primary preoccupation. Through an expression of resentment like "*Ou lage m*," the speaker is making an accusation with an undercurrent of resentment, and often, desperation.

Finally, a gift's absence may also lead to resentment on the part of hopeful solicitors or potential recipients. This was particularly noticeable if one was not chosen to receive aid and others were, or if a prior source of aid was discontinued or diverted. There are a variety of scenarios in which this happens: solicitations for aid may be refused outright, the source of aid may cut contact or not return communication, or the aid may simply stop without efforts by any of the parties involved to articulate what has happened.

All of the processes described above can be illustrated through ethnographic examples, both from my research, and also in the work of other scholars. Anthropologist Karen Richman (2005) has reported that some of her informants in Haiti pretended to not have received transfers from relatives in the United States so that they would have to be beholden to them.[51] During my

2. Richman does not elaborate on this phenomenon, so it is difficult to establish what precisely is so unpalatable about receiving money from a younger sister in Brooklyn. A reversal of gender and age roles? Being unable to reciprocate? Being forced to reciprocate by performing

research, I found that it was common for recipients to disparage aid or minimize its importance, which, in addition to reflecting straightforward appraisals of the aid, could also act to counter humiliation, and to rectify the imbalance that accompanied the inability to reciprocate. The resulting statements voiced resentment based on various claims: "They only give you a little bit, and it gets used up right away. It's as if they don't really want you to stand on your own two feet." Or: "They only send you what they don't need anymore. A lot of times it's not what we need – broken equipment, the wrong medications, expired drugs… and then we're stuck trying to get rid of it." It is tempting to try to distinguish between comments that "accurately" reflect critical perspectives on aid, and those that are "strategic" expressions that attempt to rectify positions of subjugation and humiliation. This, however, is not my intent; rather, I feel it is more important to acknowledge that the two purposes are not mutually exclusive, and that these positions of resentment also exist alongside sentiments of gratitude and appreciation for those aid interventions which are perceived as useful and helpful.

It is also important to note that while resentment may be most obvious among the recipients and solicitors of international aid, it is also an emotion that is experienced and expressed by donors and providers. Many of the situations above also apply to donors, who they themselves are often in the position of soliciting funds from large funding bodies, such as foundations, governments, and universities. In addition, resentment is one of the many emotions donors

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unpleasant tasks? Or simply because denying the receipt of a gift is a tacit request for its replacement?

experience when receiving solicitations. Donors often spoke in an exasperated tone about solicitations that immediately follow the provision of aid: in classic gift models, gifts should be followed by a reciprocal gift or a certain lapse of time, not an immediate request for an additional gift. Donors experience resentment when the aid they have provided is not used as intended or does not achieve the desired results, when recipients appear ungrateful for the aid, or when various factors impede or complicated the aid process. As in the case of recipients and solicitors, resentment co-exists with a host of other emotions. For volunteers or aid workers visiting Haiti for the first time, the emotions they most often expressed were excitement and enthusiasm at being in Haiti, pity and dismay upon seeing the conditions there, admiration and awe for qualities they appreciated among Haitians, and guilt and self-scrutiny as they pondered the discrepancies between their own relative good fortune and the hardships and deprivations they observed. Resentment appeared to be more common among foreigners with more experience in Haiti or working with aid organizations in similar conditions.

In addition, while my descriptions above were primarily intended to frame Haitian health professionals' resentment toward international medical interventions, I should emphasize that these same individuals experience and express as much (if not more) resentment toward the Haitian state and their own national *dirijan*-s (leaders). Common expression of this resentment takes the following forms: rhetorically declaring that the population has no state or leaders - *"Nou pa gen dirijian," "Pa gen leta,"* ("We don't have leaders," "There is no

state,") - attributing the state's failures to a lack of conscience *(konsyans)*or to ill will on the part of officials, or in some cases, extrapolating Haiti's current conditions to a condemnation of all Haitians' character and capacity. For example, one young Haitian physician told me:

> "If they were to give an American state or a Canadian province to Haitians and tell us that we could all move there, and the people from up there would come to Haiti, I would stay here. Because you can be sure that if you gave Haitians a place with lots of resources that was doing fine, they'd find a way to screw up and make things as bad as they are here."

Such sentiments, of course, exist alongside strong feelings of national pride and recognition of Haitians' enormous accomplishments and achievements, both in historical terms, and in being able to survive and endure under current hardships. This contradiction and the ironies that accompany it are a frequent topic of conversation in Haiti.

Resentment as experienced by individuals can be withheld or expressed, and expressions of resentment can be discomfiting for those toward whom they are directed. Many of the Haitian health professionals I observed engage in certain practices and behaviors that minimize their contact with expressions of resentment by poorer Haitians. These include living and working in specific (and often exclusive) spaces, maintaining an authoritarian demeanor when dealing with individuals of lower social classes, and, in clinical settings, relegating triage, fee collection, and logistics to lower-level administrative and security staff. Whether these practices and behaviors are explicitly designed to avoid resentment, or whether they are carried out with other objectives (security, comfort, convenience), is difficult to determine. However, an outcome of these behaviors is that contact with expressions of resentment is minimized.

The foreigners I met in Haiti are often struck by and critical of manifestations of class conflicts in Haiti. These include various forms of exclusion and discrimination, violence in both explicit and structural forms, and the expression of sentiments, opinions and values that reflect class and color-based prejudices. Many of my foreign informants expressed criticism about the measures middle and upper class Haitians take to isolate themselves from their poorer compatriots. They often spoke to me of their own discomfort with many of the class-based privileges they experienced during their stays in Haiti, including access to comfortable lodging and housing, private transportation, and interactions with domestics employees. This discomfort was sometimes marshaled into a critique against the Haitian elite, with foreigners saying that they themselves would be unable to live a comfortable lifestyle with the knowledge that such poverty and suffering was in such close proximity. Some suggested that this elite had become desensitized to the suffering of others due to repeated exposure. Most, however, did not acknowledge that their own stays in Haiti were relatively short-term, and that their attitudes and behaviors with regards to differences in social classes and access to resources were conditioned by the fact that their encounters with poverty of the type found in Haiti were relatively fleeting, as opposed to their Haitian partners and colleagues, for whom managing relations across extreme disparities in resources and status is a prolonged and constant concern, and part of their daily lives and routines.

Contemporary conflicts between foreigners and the Haitian elite have long historical antecedents, which can be traced back to the colonial period. Some of

the most virulent conflicts in Saint-Domingue and occurred between white colonists and members of the local elite, who were often of mixed European and African ancestry. Some of the central conflicts revolved around whites restricting the access of non-whites to certain echelons of political and economic power, judgments made on the moral and intellectual capacities of different groups based on racialized classifications, and the relations whites and non-white elites would have with slaves. In writings about Haiti, elites are sometimes referred to as MREs: "Morally Repugnant Elites" or "Most Repugnant Elites," to which at least one of the group's members has replied, "We are not the most repugnant elite, we are equally repugnant! (Fatton, xii)" Middle and upper class Haitians, conversely, will cast judgments on the foreigners who come to Haiti, accusing them of racism, boorishness and greed. Historical roots of these aspersions are visible in the *grands blancs / petits blancs* distinctions that were made between upper-class, gentry whites and low-status artisans and indentured laborers in Saint-Domingue. In the early 19th century, under the looming threat of American influence and invasion, Haitian intellectuals would justify the discrepancy between their francophilia and the nation's colonial past by arguing that the *colons* in Saint-Domingue represented the dregs of French society (Hoffman, 1984). Echoes of these sentiments can still be heard from time to time today, when Haitians complain about the quality of the foreigners who come or are sent to intervene in their country.

***Ressentiment***

Thus far, I have discussed the emotion of resentment as it is most commonly and understood. I now turn to a discussion of *ressentiment*, the concept developed by Nietzsche in his "Genealogy of Morals," and subsequently developed and revised by a lesser-known German philosopher, Max Scheler. Nietzsche used the term in French because it captured something for him that German did not. He traces *ressentiment* to the hatred of enslaved and oppressed peoples, specifically "the Jews," who are responsible for a "slave revolt in morality." *Ressentiment* is for Nietzsche the love that grows as the crown of this hatred. It is creative and produces values: "The impotence which requites not is turned to 'goodness,' craven baseness to meekness, submission to those whom one hates, to obedience… […]. The inoffensive character of the weak, the very cowardice in which he is rich, his standing at the door, his forced necessity of waiting, gain here fine names, such as 'patience,' which is also called 'virtue'; not being able to avenge one's self, is called not wishing to avenge one's self, perhaps even forgiveness […] (Nietzsche, 2003: 27)." Nietzsche bemoans this development, and while its anti-Semitic dimensions are clear, he goes on to claim that Christian love is the "most delicate flower of *ressentiment*." Nietzsche's texts, bombastic and unsettling, may have more use for social scientists as provocations rather than as empirical studies: "The real strength of Nietzsche's moral psychology lies in his insight into the pathological deformations of personality associated with modern moral consciousness, especially where they involve the interplay of emotional forces and evaluative ideals (Wallace, 2007: 111)." While I take exception to the phrase "pathological deformations," the

"interplay of emotional forces and evaluative ideals" is indeed fertile ground for anthropological theory.

Nietzsche's work on *ressentiment* was developed and critiqued by his compatriot Max Scheler, a philosopher best known for his work in phenomenology and ethics. In 1915, Scheler published *Das Ressentiment im Aufbau der Moralen* (The Role of Ressentiment in the Make-Up of Morals), a work that develops, refines and critiques Nietzsche's concept of *ressentiment.* Scheler's strongest critique of Nietzsche's analysis involves the latter's characterization of Christianity as the "flower of ressentiment." A central chapter of Scheler's work is devoted to arguing that Nietzsche confounded Christian love and *ressentiment.* *Ressentiment* exists, Scheler argues, and it exists very much as Nietzsche described it. However, his predecessor misjudged the essence of Christian morality, which itself had been deformed through time. Scheler describes a Christian love that is "entirely free of ressentiment (Scheler, 2003: 59)," and stems instead from "inner security and vital plenitude (60)." Contrary to *ressentiment:*

> "When a person's spontaneous impulse of love and sacrifice finds a specific goal, an opportunity for applying itself, he does not welcome it as a chance to plunge into such phenomena as poverty, sickness, or ugliness. He does not help this struggling life because of those negative values, but *despite* them – he helps in order to develop whatever may still be sounds and positive. He does not love such life *because* it is sick poor, small, and ugly, and he does not passively dwell upon these attributes. (61)"

Because Scheler is so insistent in his desire to distance Christian love from *ressentiment* and its manifestations (namely humanitarianism and other forms of love), he elaborates on and develops these concepts in ways that Nietzsche did not, generating ideas that are applicable to my own analysis. Scheler agrees with

Nietzsche that *ressentiment* is the root of "humanitarianism," or "love toward every member of the human race (79)." He writes,

> "The humanitarian movement is in its essence a *ressentiment* phenomenon, as appears from the very fact that this socio-historical emotion is by no means based on a spontaneous and original *affirmation of a positive value,* but on a *protest, a counter-impulse* (hatred, envy, revenge, etc.) against ruling minorities that are known to be in the possession of positive values. "Mankind" is not the immediate object of love (it cannot be, for love can be aroused only by concrete objects) – it is merely a *trump card* against a hated thing (85)."

Other relevant arguments by Scheler include the claim that humanitarianism, because it identifies love for specific individuals or particular groups as taking away from a generalized love of mankind, is incompatible with patriotism, that because of its emphasis on humans' common attributes, humanitarianism "becomes primarily directed at the *lowest,* the *animal* aspects of human nature (86), and that humanitarianism is in fact a "peculiar from of sham love founded on self-hatred and self-flight (87) ." I will now turn to a discussion of the applicability of *ressentiment* and its purported manifestation as humanitarian love to the case of international medical aid activities in Haiti.

At first glance, Haitians appear to fit Nietzsche's characterization of a subjugated, oppressed and impoverished population. With a legacy of brutal slavery, the Haitian people have been unable to secure for themselves the success, wealth and power they aspire to, and commonly identify other countries (particularly the United States and France) as comprising a "hostile external world." The moral values that Haitians create and sustain, therefore, would be the result of *ressentiment,* a modern-day example of "creatures who, deprived as they are of the proper outlet of action, are forced to find their compensation in an imaginary revenge (Nietzsche, 2003: 19)." The foreigners who come from

wealthy countries to Haiti, aristocrats of the contemporary world, would be branded as "evil" and "exploitative" by impoverished Haitians, who would understand themselves as closer to God and goodness because of their lowliness and suffering. As appealing as this interpretation might seem, my own empirical research and observations suggest that *ressentiment* could only be applied to this context with major modifications, and may be as useful for what it omits as for what it includes.

The first modification is the attribution of *ressentiment* to a specific population. While Haitians do experience and express resentment towards countries, institutions and individuals that they view as more powerful than their own and themselves, foreign aid workers and volunteers also experience resentment toward Haitians, as I described above. In addition, I found foreigners to be much more likely to emphasize, represent and at times even celebrate Haitians' poverty and misery than Haitians themselves. The pressures toward upward mobility are extremely strong in Haiti, as evidenced by a desire for economic advancement and the migration toward cities and foreign countries in search of various kinds of resources. I found in my research that poverty in its different manifestations (appearance, clothing, behavior, and at times individuals themselves) was generally derided, disparaged and mocked by Haitians of all social classes, whereas for many foreigners, poverty represented something authentically foreign and Haitian. Encounters with the poor were considered to be particularly moving and redeeming: many aid workers and volunteers spoke to me of how much they had learned from people who "have so little but are so

happy." Representations of poverty and suffering are common currency among aid organizations, many of whom use images of naked and dirty children, peasants in rags, and slum housing unproblematically.[52] If the dimension of *ressentiment* that involves an uplifting of poverty and suffering is to be applied, in this case, it should be associated with the privileged and the powerful rather than the subalterns.

Another dimension of *ressentiment* which calls for modification in the context of empirical research involves the assignation of blame. According to Nietzsche and Scheler, those experiencing *ressentiment* would blame others for their misfortunes, namely the powerful, and reserve for themselves an exclusive claim to goodness, purity and morality. During my research, I found that while many Haitians will blame foreign governments and individuals for their country's problems, it was as common (if not more so) to hear them lay blame on themselves as a population for their own misfortunes. By using the frequently-heard phrase "*Ayisyen mechan*," (Haitians are mean), Haitians regularly accuse themselves and their fellow citizens of greed, cruelty, selfishness and incompetence. To be sure, colonial legacies and centuries of racist and classist discourse on the inferiority of African peoples and their descendants should not be dismissed. For example, the Haitians who told me that their country was "Satan's country" because their ancestors had participated in Vodou ceremonies that launched the country's independence movement are perpetuating the

[52] For others, the use of such images represents a dilemma. The director of a small aid organization, a Haitian-American with a strong sense of Haitian national pride, told me about her internal conflict about whether or not to use images and anecdotes of the infamous "mud pies," as she knew these presented a humiliating aspect of life in Haiti while at the same time could be instrumental in garnering increased funding and support for the organization she directed.

interpretations of colonial masters and foreign missionaries who conflated African religious practices with satanic activities and witchcraft. When Haitians describe the characteristics of their own people, they do so with the influence of such inherited discourses.

And yet, Haitians are also known for their fierce national pride, and I often heard them evoke not only their national accomplishments in historical terms (the Haitian Revolution being the foremost among these) but also contemporary attributes that characterized Haitian people: their resourcefulness and determination, their attachment to education and learning, and their warmth and generosity. These contradictions reflect a much more complex moral world than that of *ressentiment*. Many Haitians are indeed pessimistic about their will and capacity as a people to govern themselves and ensure a successful society. As was illustrated in the comment above concerning what would happen if Haitians were given part of another country, many Haitians *do* hold themselves as a national population accountable for their weaknesses and failings.

Many of my discussions and interviews on international aid with Haitians ended with my ended with my informants stating, "In the end, it's up to Haitians to be responsible for our own country," affirming the primacy of Haitian sovereignty and suggesting (if not explicitly stating) the capacity of Haitians for self-governance. In response to a question about foreign countries' obligations toward Haiti, one young clinician responded, "Haitians should be in charge of the foreigners here. We can't give them full responsibility, it's our duty as Haitians to take responsibility… but real, authentic Haitians, who don't walk with their

heads down, who don't let others order them around or do what they want." Statements such as these fall into a long-tradition of rhetoric favoring self-governance and self-determination by Haitians. The frequency of these comments among my informants may stem in part a reflection of my informants' social position: it's possible that poorer or more vulnerable individuals would be less attached to the ideal of Haitian sovereignty. As a taxi driver told me, "We should just give the country to the foreigners and let them fix it. All that talk about independence and liberty, that's just what the elites have been telling us to keep us quiet so that they can crush us." Even some of my health professional informants expressed the opinion that a foreign power would be more successful at managing Haiti and the well-being of its population, and use the case of the French-overseas departments of Martinique and Guadeloupe to illustrate this claim. In short, the ambivalence expressed by people in Haiti about responsibility for their country, both in terms of its historical trajectory and uncertain future, reflect a less totalizing moral framework than that of *ressentiment.*

Because I chose to focus primarily on the work of secular organizations in my research, it is difficult for me to comment on the religious dimensions of international aid, which could also be examined in the context of theories on *ressentiment.* It is important to acknowledge that while secular organizations such as Konbit Sante may design, execute and perceive their interventions in secular terms, their work cannot be completely untouched by the legacy of North American medical and aid activities, which were profoundly shaped by Judeo-Christian religious traditions. In addition, their work may be perceived and

interpreted by recipients in religious terms. The following excerpt is from a speech by the head pediatrician at the HUJ at the inauguration of a new pediatric emergency room funded by a grant obtained by Konbit Sante. After opening with a list of Haiti's and the world's woes (natural catastrophes, crises and man-made disasters), he stated:

> "In spite of it all, the hope for our redemption is there, germinating in the hearts of a group of men and women who come from far away, who break down the divisions caused by taboos, racial prejudice, and economic class; people whose only compass is the love of their neighbor, this love for Christ the Redeemer. These people are subjects of universal love, total love, dis-interested, blind, without distinction. These aren't hypocrites who come to get a free ride off the backs of the Haitian people, who come to exploit the distress of the poor."

The members of Konbit Sante who were present for this event did not express any objection to the characterization of their work in these terms, although many of its members told me that they did not did not consider their work to be religiously motivated, and would prefer not to be considered a religious organization by the people they work with in Haiti. Some of its members told me that the group's lack of religious affiliation or undertone was part of what had attracted them to it, after having negative experiences with faith-based or missionary groups. And while the group may be influenced by a larger Judeo-Christian legacy, Konbit Sante doesn't use religious rhetoric or language, did not emerge out of a religious movement, and although it has historically teamed up with American churches to share resources or logistical capacity, it keeps a very secular profile. I have attempted to take this secular identity seriously, as I believe it is indicative of a larger trend in contemporary international aid movements. However, explicitly faith-based aid initiatives are still common in settings like Haiti, and further research into the relationships between their values, moral economies and

interventions would contribute to a better understanding of how *ressentiment* is experienced and negotiated in contemporary societies.

Rather than attach *ressentiment* to a people, I am looking for ways to link it to processes, of reciprocity, obligations and expectations, as well as the ways these are fulfilled or left hanging dangerously. Understanding these processes and the moral emotions and economies that they operate with and through is more than a theoretical exercise – it has consequences for informing potentially life-saving interventions that too often do not achieve their intended results.

## Conclusion

In this dissertation, I have attempted to accomplish two main objectives: 1) to describe and analyse the process of international medical aid and related phenomena in Haiti, a subject that had not previously received the scholarly attention of anthropologists and 2) to use this historically and temporally specific case study to provide insight into the processes by which individuals and organizations negotiate inequalities, obligations, gifts, and their moral and emotional dimensions. The specificity of my field site, my choice of methodology, and the theoretical and disciplinary orientations that guided my research have both strengths and limitations: while allowing for an in-depth analysis that revealed contradictions, ambiguities and diverse perspectives, it would be presumptuous to apply my findings to other settings without the benefit of further, comparative studies. I therefore echo an increasing number of calls for further studies on aid and humanitarianism, specifically those which examine the central role that medicine and health play in the efforts to alleviate the suffering of strangers and reduce disparities in resources and opportunities. I now turn to avenues for further research in the areas addressed in my dissertation.

In Chapter 1, I described the lives and work of Drs. Albert Schweitzer and Paul Farmer, and argued that the figure of an international medical hero has been central not only to depictions and representations of transnational health projects, but also to the projects' activities and very existence. It will be important to follow Paul Farmer's work in the coming decades, as he is likely to continue to

have great influence not only on Partners in Health's continually expanding projects, but also in the area of global health more broadly, as his frameworks and projects continue to attract international attention. Although the figure of the international medical hero has been a prominent feature of international and global health for over a century, it remains to be seen if this prominence will endure. This dimension of international interventions should also be considered in light of new and emerging donors, specifically groups and governments from outside of North America and Western Europe.

I used the example of Konbit Sante in Chapter 2 to highlight a series of issues and tensions related to contemporary, secular medical aid. Some of the challenges the organization faces are ongoing, while others will emerge in the coming years. For example, how will the organization deal with the aging and retirement of some of its most active American members? How will the organization's choice to work in a single project site fare in the climate of contemporary global health initiatives, which favor interventions in multiple countries? As with any group partnering with the Haitian government and MSPP, it is unclear how these partnerships will fare in Haiti's uncertain and unpredictable political climate. My research on Konbit Sante also brings into relief some of the specificities of secular humanitarian interventions. While I am reluctant to reinforce the dualism of a secular/sacred binary that may not correspond to lived experiences or realities, the ongoing overlap and friction between organizations and individuals with diverse relationships to faith-based models and approaches warrant further investigation and reflection.

Chapter 3 shed light on the situation of health professionals in Haiti, specifically the country's young medical residents. Like so many of their compatriot colleagues, nearly all of the physicians I spoke with expressed their intention to leave Haiti, and if current emigration rates are any indicator of future tendencies, it appears likely that most of them will succeed in their goal. In light of current transnational practices by Haitian migrants and the dynamic flows of people, resources, technologies and ideas that characterize the diaspora, further research will be needed to understand the lives of emigrant health professionals and their involvement in health services in Haiti. In addition, while my research focused on physicians, more work is needed on other health professionals in Haiti, specifically nurses and health agents. The former are particularly important for their relatively high numbers in the country's health system, and the latter for their growing presence among medical aid agencies, who increasingly consider community health agents to be essential to project implementation. Particularly in the case of health agents and lower-status employees, the distinction between impoverished patient and health worker may not always be evident. Understanding provider/patient relations in broad perspective has implications not only for social science and theory, but also for program implementation and success.

The issue of coordination, discussed in Chapter 4, has received signification attention in the aftermath of the 2010 earthquake and cholera outbreak (see below). While I argue that the conflicts and undesired outcomes related to coordination do not result solely from technological or logistical

limitations, the emergence and prevalence of internet-based technologies for communication and coordination do represent a watershed in terms of international interventions. It will be important to examine the consequences of these developments in broad terms, and to be particularly attentive to issues of power, inclusion/exclusion, and discretion that the use of these technologies raises.

Finally, my discussion of international medical aid to aid in terms of moral economy and *ressentiment* offers new ways of understanding a complex phenomenon with diverse actors, motivations, objectives, values and histories. As part of a larger effort by anthropologists to address issues of humanitarianism and transnational moral exchanges, I hope that this work will succeed in its goal to take seriously the lives and claims of those involved in these processes. In considering that every word in the title of this text ("Where – They - Need - Me") is subject to diverse interpretations and rhetorics, it becomes clear that this is a task that has only begun.

## Epilogue

Geology and history wrote a more dramatic ending to this dissertation than I could ever have imagined. Seven months after I completed my fieldwork, a catastrophic earthquake measuring 7.0 on the Richter scale struck southern Haiti, devastating Port-au-Prince and its surrounding areas. Estimates for human casualties range from between 200,000 and 300,000, although a lack of reliable census data, the inability to retrieve many of the victims' bodies, and the internment of thousands of corpses in mass graves make the exact number impossible to calculate (OCHA, 2011). The loss of infrastructure was also devastating – 28 out of 29 government ministry buildings collapsed during the quake and its aftershocks (MacFarquhar, 2010), and countless homes, workplaces, schools, and churches were reduced to rubble, rubble which, over a year after the quake, continues to impede the rebuilding process and even the most basic flows of traffic.

In the days that followed the quake, the medical response from abroad was swift and spectacular. Working under the auspices of governmental and non-governmental agencies, disaster, rescue, and emergency medical teams freed Haitians from under trapped buildings, set up temporary hospitals in tents and hangars, and worked to save earthquake victims from death by blood loss, infections, and shock. In the hours and days after the quake, the need for medical care far outweighed available medical resources, and it's impossible to know how many people died from lack of basic care. The most common injuries were

caused by falling walls and collapsing buildings – victims were treated for blunt trauma and crushed limbs. A relief worker described many of the wounds as "tiger slashes": these were usually vertical gouges from falling cinder blocks. In the weeks that followed, after the patients with traumatic injuries had either been treated, or died from their injuries, the population's medical needs returned to their tragic pre-quake banality: water-borne infections (exacerbated by water scarcity in crowded tent camps), complications related to pregnancy and childbirth, and the ravages of malnutrition and unsafe living conditions.

I returned to Haiti for a brief period shortly after the earthquake, spending a week in Cap-Haïtien and several days translating for American relief workers at a field hospital in Port-au-Prince. Cap-Haïtien, like most of the country, had not sustained any direct structural damage from the earthquake, but the population was still reeling from the shock of losing relatives, of the economic perturbations the quake engendered, and the symbolic and pragmatic ramifications the catastrophe had for the Haitian nation. Medical activities in the area were seriously affected. As in other Haitian cities, municipal officials in Cap-Haïtien arranged for the transport of people from the area who had migrated to the capital, including injured people requiring medical care. Many of the earthquake victims made their way north with the help of families and friends, and before long, NGOs were involved in the transportation of people needing medical care to hospitals in the area. The Hôpital Sacré-Coeur in nearby Milot received hundreds of patients, drawing on their capacity to integrate foreign medical teams in their work and to receive donated supplies from foreign donors. That hospital's

administration and board set up tents on the hospital's property to expand their capacity from 75 inpatients to nearly 400, and US Coast Guard helicopters airlifted injured patients from Port-au-Prince to a makeshift launch pad near the hospital.

At the HUJ, the influx of patients was much less dramatic. The hospital received approximately sixty victims in the days that followed the quake, and several of the hospital's staff expressed their frustration at the administration's incapacity to respond effectively to the situation. A few days after the event, the hospital's administration became so overwhelmed with offers of aid by foreign agencies, groups and individuals that they asked Konbit Sante to become the official contact point and liaison with the hospital's international's partners. This act testifies to not only to the number of actors involved and the complexity of the situation (one that would compel the hospital's administration to relinquish its strategic position as hub in dealing with international partners), but also the administrators' trust in and appreciation of Konbit Sante, to the extent that they would entrust the group with a position that required so much careful strategizing and could potentially confer so much power and privileged access to resources and relations.

Rather than fundamentally alter the processes I have described in this dissertation, the earthquake, its aftermath, and the international medical responses to it amplified many of the tendencies and phenomena I observed during my fieldwork. For example, as material donations represented both a source of tangible benefits and sources of conflict, they continued to do so in the weeks and

months after the quake, when material donations to the hospital increased drastically. The issue of coordination, which appeared so prominently in the discourses of my informants, became an even more visible theme as the number and provenance of international actors carrying out interventions increased after the earthquake (Hopmeier et al., 2010). Finally, although the context changed from one of long-term development planning to short-term disaster relief, the issues of obligation and responsibilities remained salient, particularly in regards to the role of Haitian medical professionals and Haitian medical institutions.

Several months after the earthquake, the closure of private Haitian hospitals and clinics became an issue of concern for Haitian medical professionals, and was described repeatedly in the Haitian press. According to standard accounts, the influx of free medical services, treatments and supplies from international actors had created a climate in which Haitian clinical establishments could not compete, and were forced to close. Their staff described with irony how they had opened their doors to all needy patients in the period immediately following the quake, and how in some cases, international bodies had used private medical facilities with what seemed to the Haitian professionals to be a tacit understanding that the latter would be compensated for their efforts or receive resources necessary to continue to function after the initial response (Nouvelliste, 2010). In addition, recent reports suggest that medical professionals are leaving Haiti's public health care system to seek more lucrative positions with international aid agencies (Batha, 2011)

What are we to make of these narratives? Not having conducted research on the topic, I can only conjecture based on my prior experiences with health care in Haiti. While it is true that patients in Haiti have often chosen to seek out care from foreigners because it is cheaper than services offered by private clinicians or considered more potent or prestigious because it comes from abroad, it seems unlikely that free care from foreigners was the single or only reason that caused private health facilities to go out of business. The reason for this is that the patients who would stand in line in a tent camp to wait for primary health care are not generally those who would have sought out or been able to care for private health services before the earthquake. These middle and upper class individuals, rather, were among those most likely and able to migrate abroad after the quake. While the provision of free health services by international agents may have contributed somewhat to a reduced clientele for Haitian medical professionals in private establishments, it was certainly not the only factor. The fact that it was widely perceived to be the primary cause of closures, however, highlights the tensions and ambivalence that exists between international and local biomedical practitioners in Haiti.

**Elections in the Time of Cholera**

After the earthquake, thousands of Haitians found themselves homeless, and while many returned to their communities of origin throughout the country to stay with relatives and friends, many returned to the capital only a few weeks after the quake. Those with the possibilities and resources to rebuild began doing

so, but for many more, their only option was to set up in one of the many tent camps that mushroomed throughout the capital, either living in tents sent from abroad by family in the diaspora or international relief organizations, or cobbling together crude shelters from sheets, plastic tarps, cardboard, and any other scraps of material. These camps lacked in the most basic infrastructure and sanitation, and while relief agencies made efforts to provide clean drinking water and latrines, epidemiologists predicted that the camps' hundreds of thousands of residents were at risk of contracting and propagating infectious diseases.

When the cholera outbreak was identified, it appeared in an unlikely area. Rather than emerging out of the squalid camps, the first cases were traced back to the Artibonite Valley in central Haiti, a region considered the country's breadbasket, with a long history of rice cultivation and subsistence agriculture. The number of cases quickly multiplied from several dozen to hundreds, then thousands. Local clinics and hospitals were completely overwhelmed, with patients dying of dehydration due to violent diarrhea and vomiting on clinic floors and in hospitals yards for lack of beds. While the outbreak seemed to slow or abate for days at a time, this was probably due to inconsistencies in reporting – Haiti's epidemiological surveillance mechanisms, hardly a reliable source of accurate information in the best of times, had been badly affected by the earthquake, and was unable to control or count cases existing in rural communities or isolated hamlets where clean water supplies are particularly elusive.

The cholera's origin puzzled many observers. Journalists alternately reported that cholera had not been present in Haiti for decades (BBC, 2010) or that it had never been documented in the country (CBS, 2010). Attention soon turned to a Nepalese MINUSTAH base in the area where the outbreaks occurred, where journalists found that sewage and waste water from the base appeared to be contaminating the local Meille River, which feeds into the Artibonite (Geffrard, 2010). Commentators noted that cholera is endemic in Nepal, and that a contingent of Nepalese soldiers had arrived in Haiti following an outbreak of the disease in their home country. As *Vibrio cholerae* can live in and be transmitted by asymptomatic hosts, the U.N.'s claims that its soldiers manifested no signs of the disease carried little weight among critical observers. During the days that followed the identification of the MINUSTAH base as a potential source of contamination, WHO officials minimized the important of identifying the outbreak's origins (Jordans, 2010). Haitians, particularly sensitive to being repeatedly identified as a source of disease, were outraged, and took public actions against the UN and its soldiers. In Cap-Haïtien and other cities around the countries, demonstrators, both peaceful and violent, expressed their dismay and fury at the situation.

As of March 2011, the number of deaths attributed to the cholera epidemic is estimated at approximately 4,600, with 240,000 reported infections (Daudier, 2011) Epidemiologists predict that the number of cases could continue to rise. The medical response to the cholera epidemic has been much less spectacular than to the earthquake. Not only are fewer people directly affected for the time being,

but a disease of this type is less dramatic than a collapsing building. Diarrhea and vomiting cannot compete with images of schoolchildren pinned under rubble or of an elderly women being rescued after days without food or water.

As in the case of the earthquake, the cholera outbreak in Haiti and international responses to it have reaffirmed many of the findings and conclusions I came to during my research. The cholera epidemic brings into relief the suspicions about what foreigners bring to Haiti, in this case a deadly bacterium. In comparing responses to the earthquake and the cholera epidemic, one returns to a long-standing tension between prioritizing emergency clinical interventions or long-lasting developments in infrastructure as preventive measures against disease outbreaks. While not as numerous as respondents to the earthquake and its aftermath, the number, scope and diversity of actors and agencies intervening in the context of the cholera outbreak is overwhelming, and coordination continues to be a complex and contentious issue, particularly in controlling a fast-spreading disease that requires various levels of diagnostic, therapeutic and logistical interventions.

In this epilogue, I have highlighted that the earthquake and cholera epidemic have not obliterated the previous context of practice of international medical aid in Haiti, but have rather amplified and exacerbated pre-existing tendencies and patterns. That being said, both of these events have significantly altered the health and medical landscape in Haiti. The earthquake represents an event of unprecedented scope for Haiti, in terms of number of sudden deaths, damage to infrastructure, and international visibility. Response to the earthquake

was also unprecedented, and highlighted the emergence of new forms of fundraising, such as donations by cell phone text message and through internet networking sites. Cholera's emergence in Haiti has already had major consequences for the country's national stability, and will doubtlessly play a major role in negotiating the terms of MINUSTAH's presence in the country. All of this is occurring in a climate of political uncertainty, as the country awaits the outcome of recent presidential elections. In addition to having a relatively low turnout, the elections' legitimacy has been questioned by a wide variety of national and international actors. The earthquake and subsequent displacement of much of the country's population was identified as a major source of troubles, was as many voters had been unable to obtain their required identification cards and many found that their names were not on the lists at their local polling stations, rendering them ineligible to vote. Accusations of ballot tampering and falsification, as well as of fraud in counting have also circulated. Both the Haitian state and nation find themselves yet again at a dangerous crossroads. The country's future and the outlooks for health of its population, remain subject to intense speculation.

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