ANTHROPOLOGICAL DEMOGRAPHY

Toward a New Synthesis

Edited by David I. Kertzer *and* Tom Fricke

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Chapter Eight

Demography without Numbers

Nancy Scheper-Hughes

I want to argue here for a particular methodology for an anthropologically informed demography, one that Margaret Lock and I have called a "critical interpretive approach" (Lock and Scheper-Hughes 1990). After a few words on the epistemological divide separating objectivist/positivist approaches from critical/interpretive approaches, I will take up an instance from my intermittent, twenty-five-year study of infant mortality in northeast Brazil in order to demonstrate what qualitative, interpretive, and meaning-centered research—demography without or beyond numbers[1]—can reveal about infant mortality that strictly quantitative and positivist research cannot.

Objectivist and interpretive approaches have been described in terms of incommensurate epistemological differences, conforming to what Thomas Kuhn (1970) called "paradigms" and what Michel Foucault called "epistemes," by which he meant different shapes of thought/knowledge/power (1972:191). A paradigm in Kuhn's sense provides a foundation for the organization of reasoning; it is a source of logical constructions devoted to the systematic production of explanations. Another meaning of paradigm is similar to the concept of *weltanschauung* (or worldview): the paradigm is that which is shared by the members of a particular scientific community (see Kuhn 1970). In other words, it organizes and legitimates the shared values of the group; it monitors the standards of what is to be considered acceptable, permitted, adequate, and good (as well as the reverse) in the conduct of research.

Objectivist and interpretive frameworks constitute paradigms insofar as they constitute very different convictions about the nature of reality, about what is considered useful or respectable data, about research and funding priorities, about the forms that data and theories should take, and about the kind of language researchers should use—in all, about the way scientists and social scientists should go about their business and how research findings should be applied to public policy and to everyday life (see, for example, the debate between D'Andrade [1995] and Scheper-Hughes [1995b] on "scientific" versus "moral" models in anthropology).

Drawing on anthropological metaphors, we could say that the worldviews underlying the two approaches represent "foreign cultures," each one self-contained and autonomous, possessing its own inner logic and standards of truth-seeking. Viewed in these uncompromising terms, it would be next to impossible to invalidate the method of one from the perspective of the other. To appropriate Evans-Pritchard's statement on Azande witchcraft, "In this

web of belief every strand depends on every other strand, and a Zande [here read an objectivist or an interpretivist] cannot get out of its meshes because it is the only world he knows. The web is not an external structure. . . . It is the [very] texture of his thought and he cannot think that his thought is wrong" (1937:193–94).

The debate turns on the old question of whether "facts" in the world are uncovered or whether they are produced in the context of research. The objectivist position assumes that rigorous empirical research can lead to a truthful and accurate representation of the objects or events under study (see D'Andrade 1995). Empiricism is a philosophical tradition which advocates (and assumes the possibility of) a neutral, value-free science, one able to apprehend reality without mediations. What is needed to settle complex problems and arguments is always more findings, more facts.

Most epidemiologists and demographers simply take for granted the fundamentally empiricist nature of their scientific practices. In his discussion of modern epidemiology, Kenneth Rothman quotes the respected physicist (but indifferent philosopher) Lord Kelvin: "I often say that when you can measure what you are speaking about, and express it in numbers, you know something about it; but when you cannot express it in numbers your knowledge is of a meager and unsatisfactory kind; it may be the beginning of knowledge, but you can have scarcely, in your thoughts, advanced to the stage of Science, whatever the matter may be" (Rothman 1986:23). Gene Hammel (1990, and chapter 7 in this volume) used to say something similar to the many cohorts of graduate students who took his excellent seminars in research methods. "If you can't count it, it probably doesn't exist." Of course, he would modify this dictum for the hopelessly qualitative cultural anthropologists-in-training. I think he was happy if I managed to number the pages of the research proposals I submitted to his seminar.

Curiously, the hard-wired notion of empiricism and the notions of objective reality and causality which derive from it just about disappeared from Western philosophy when modern science appeared on the scene as a social practice. While there are few radically empiricist philosophers left in the Western world, there are countless practicing and practical scientists and (even worse!) social scientists who operate in the laboratory and in the field as if a radical critique and reassessment of empiricism had not taken place over the past 150 years![2] The commitment to positivism and empiricism is so unconsciously defended that when a radical critique of it appears it is often misunderstood, as recent intellectual biographies of the early philosophical writings of Ludwig Wittgenstein demonstrate (see Malcolm 1994).

The critical interpretive approach in anthropology—and specifically in medical anthropology—calls into question the epistemological status of the objects and the realities under study. It conceives of the body, illness, disease, and death as simultaneously biological and social (Scheper-Hughes 1994a),

and conceives of the social as historical, complex, fragmented, conflictive, uncertain, and constantly negotiated. Because research takes place within a social field it cannot possibly be neutral or value free. At the very least it partakes of the culture (and hence the morality) of the scientific community where values are no less strong simply because they remain unarticulated (see Rabinow and Sullivan 1979; Rorty 1979).

In critical interpretive anthropology what matters most are the means through which research data are acquired, the various and complex meanings these findings might have, and the relations between the kinds of knowledge generated and the maintenance of powerful ideologies and forms of dominance, both social/political and biomedical/scientific. In all, interpretive research is less concerned with orderly explanations than with achieving a fuller, richer, deeper understanding of social life as the "negotiation of meanings" (Marcus and Fisher 1986:26). It is part of a broader movement in which reductionist science as a whole is reappraised as a product of its specific historical and cultural contexts.

The Radical Challenge

While conventional research in demography and/or epidemiology can strive to be culturally sensitive and can illuminate, for example, the cultural logic and alternative shapes of rationality that may govern the fertility and reproductive decision-making of Third World women, poor people, immigrants, refugees, and other marginalized "others," there is often a striking lack of awareness of the ways in which the culture of their science structures the questions asked and overdetermines the findings. Rather than simply including or factoring in reductionist and unproblematized cultural variables—and thereby "cutting culture down to size" as Kertzer (in press) put it in his contribution to another volume—a critically interpretive demography would have to become a much more radical undertaking, one which calls into question the neutral and objective status of its research categories as well as the adequacy of its interventions.

Almeida Filho has begun this radical process for the science of epidemiology (1989, 1990, 1991). He has examined the question of the object of knowledge in his field so as to interrogate further the dominant statuses of causality and of risk as they operate in conventional epidemiological inquiries. He argues that to date the best that the radical epistemologic critique can offer epidemiology is "the paradigm of what is missing, of what needs to be construed, what is [still in the process of] becoming in order to fill the gaps" (Almeida Filho 1991:6). I hope that the anthropological essays included in this volume can do the same for the science of demography—that is, to point to demography's gaps, to suggest what may be missing, and to indicate what still needs to be construed.

Recently, T. M. S. Evens referred to anthropology as the most "implicitly

revolutionary" of the human sciences (1995:12). The as yet unrealized radicalness of anthropology's epistemology derives from its "constituting interest in otherness" which renders it "open" in a definitive way. However, the lure of easy empiricism constantly undermines and subverts anthropology's radical promise. It does so each time anthropology is presented (or presents itself) as a "body of accumulated knowledge, rather than as a discipline obliged by the character of its subject matter to continually round up for interrogating the presuppositions according to which it proceeds" (Evens 1995:12).

Reality is, of course, always more complex, contradictory, and elusive than our limited and partial theoretical models and methods allow. And even those who, like myself, question the truth claims of objectivist science do not deny that there are any meaningful and discoverable facts in the world. Some things are incontestably factual and these need to be studied empirically. In my own research I am deeply committed to finding better ways of getting at crucial but elusive data, whether through better ways of mapping, predicting, and responding to the global HIV/AIDS epidemic (see Scheper-Hughes 1994b) or of unmasking the culture of silence that hides the new practices of "political disappearances" in Brazilian *favelas* (Scheper-Hughes 1992 ch. 6, 1995b).

Moving toward my main illustration, as I noted elsewhere, either 150 or 350 children die of hunger, diarrheal disease, and dehydration in the Brazilian shantytown of Alto do Cruzeiro in a given year, and the researcher who is exploring infant mortality has a strong scientific and moral imperative to get it right (Scheper-Hughes 1992:23). In Third World situations there are a great many lives and deaths to count among populations generally thought of as not worth tracking at all. But necessary empirical research of this kind need not be empiricist—that is, it need not entail a philosophical commitment to Enlightenment notions of reason, objects, and truth. Empirical work can be guided by critical-interpretive concerns about the inevitable partiality of truths and about the various and contradictory meanings that facts and events have in the existential, cultural, and political sense.

Demography without Numbers: Counting Angels

Since 1964–66 (with subsequent field research in 1982, 1986–87, 1989, 1990, and 1992) I have been working in a northeast Brazilian sugar plantation town I call Bom Jesus da Mata in order to document, analyze, and explain the causes, meanings, and the effects of infant and child mortality on a population of impoverished and chronically hungry sugar cane cutters and their families. My work began during the imposition of the military dictatorship and followed through the years of the so-called Economic Miracle up through the period of democratization.

Keeping track of "angel babies" in the plantation zone of northeast Brazil—the poorest and Third World sector in an otherwise First World nation that boasts the world's eighth richest economy—is as daunting as attempts by

U.S. census workers to count the homeless in American cities. Much of the phenomenon is tucked away from public scrutiny. The reference to a demography without numbers is, in the first instance, descriptive. As anyone working in the Third World knows, both official statistics and survey research are unreliable. An estimated one million children younger than five years old die each year in Brazil (and more than half of these die in the large, impoverished northeast region). But the official statistics are at best a rough approximation of a vastly unreported phenomenon. Brazil's national system of vital statistics was only established in 1974, although local statistics for the municipalities of state capitals and large towns are available for earlier dates. These are, naturally, of greatly varying quality.

As demographers are well aware, public records—whether official censuses, birth and baptismal certificates, marriage and divorce records, or death or burial certificates—are not pure, accurate, or objective sources of information. Nor are they politically, let alone scientifically, neutral. The public records and the statistical inferences based on them are less mirrors of realities than filters and collective representations. At best, official records and statistics reveal a society's particular system of classification as well as some of its basic social values, such as what is deemed worth recording and counting at all.

Censuses and other public records count some things better than others. In rural northeast Brazil the death of a marginalized shantytown baby is an event considered hardly worth documenting at all. The moral economy of public health and medical services in rural northeast Brazil is such that two-thirds or more of those infants who die do so without a medical diagnosis, evaluation, or testimony. The space for recording the infant's cause of death on the official death certificate is simply left blank, a conspicuous semiotic zero representing the inconsequentiality of the infant's civil status in Brazil. Even when the cause of death is recorded the information given is often meaningless, careless, or useless.

Of the 881 infant and child deaths recorded in the civil registry office of Bom Jesus da Mata—a medium-sized sugar plantation town in the northeast state of Pernambuco with a population of roughly 30,000 people—over three sample years (1965, 1985, 1987) only 159 carried a cause of death. And 35 percent of these attributed the baby's death to the incontestable but rather useless diagnosis "heart stopped, respiration stopped." The infants died, we might suppose, of having lived. Other commonly listed causes of death included "prematurity," "weakness," "hunger," "dehydration," "accidental death" (including, more specifically at times, "knock on the head," "fall," "drowned," "poisoning") and the mytho-poetic "acute infantile suffering." As there was no follow-up of any kind, "the state" seemed to demonstrate an appalling lack of curiosity about the "natural" or "accidental" causes of deaths of so many "acutely suffering" angel babies.

As many as a third of all infant deaths are unrecorded altogether. Although by constitutional law poor Brazilians are exempted from paying birth and death registration fees, in small rural towns and rural villas in northeast Brazil the civil registry office is often privately owned and the fees charged for birth, death, and marriage certificates are prohibitive for the poorest population. Consequently, many needy parents postpone birth registration for several years and only register the deaths of those babies they intend to bury in the municipal cemetery. The majority of stillborn and a great many premature infants who die at home are simply buried privately in the backyard *quintal* or in the countryside without the benefit of either a birth or a death certificate. In rural areas where older, traditional customs prevail, the deaths of unbaptized infants of any age are unregistered because as "pagan" infants they are stigmatized creatures. They are buried secretly by their parents at a crossroads, the place where Exu, the African-Brazilian deity, and his host of unbaptized spirit infants gather and congregate to serve as messengers for good and ill in the world.

Fifteen percent of births in the shantytown still take place at home, keeping half a dozen elderly midwives regularly employed. These lay midwives (unlike those attached to hospitals and maternity clinics) work in relative isolation from the agents of medicine and the state and, as they fear running afoul of the law, they do not encourage registration of the births, let alone the infant deaths, in which they have been involved. This is not, however, to malign the skills of the rural *parteiras,* for their record of maternal morbidity/infant mortality fares well in comparison to the very high number of perinatal deaths for "charity" patients at the single, privately owned but publicly supported, municipal hospital of Bom Jesus.

In cross-checking the official vital statistics on children's deaths (from birth to five years) reported for 1984–85 in Pacatuba, Ceara (northeast Brazil) against their own door-to-door household survey and interviews with women and their local healers, Nations and Amaral (1991) found that the civil registry office recorded only 44.4 percent of actual child deaths, underreporting the phenomenon by 56 percent. They also found that the official death registry and household survey techniques were less sensitive than the "folk" demographers and death reporters in detecting the deaths of less-valued females and newborns of both sexes.

In order to capture the social reality of infant and child deaths and to uncover the layers of cultural meaning underlying the metaphorical causes of death listed in the death certificates required cross-checking the official data against the oral tradition. This meant relying on the memories and self-reports of poor shantytown women as mothers and as traditional healers, praying women, and midwives. It meant, first of all, leaving the civil registry office in order to walk the length and breadth of the poor *bairros,* shantytowns, and outlying rural hamlets of Brazil in order to follow pregnancies, births, and

sicknesses (and their medical treatments and cultural healings) and the premature death of infants and children. It meant attending wakes, trailing after infant and child funeral processions, examining old and new and reused grave-sites, and talking with all those who are involved with the production, death, and burial of "angel babies."

Among the folk demographers of infant death in rural Pernambuco are the Catholic priests and nuns who baptize infants and babies, the pharmacists who prescribe for them, the hospital attendants who just as often reject as attend to them, the local coffin makers who fashion little shoeboxes of cardboard and crepe paper, the local seamstresses who sew the shrouds for infants and the little white albs with the blue sash for older children, and the shopkeepers at the open air market who sell the other ritual materials used at infant wakes: white candles, blue and white cloth, silver gummed stars, white stockings, flowers, etc. What these people don't know the taxi cab drivers, who carry mothers and sick infants to the clinics and hospitals or who may occasionally transport a father and his dead infant to the public cemetery, might know What they don't know the local gravedigger is sure to know. Their often stigmatized and rejected knowledge can fill out the social context within which infant deaths occur.

When asked "How many poor and how many rich infants did you bury in the past month?" Seu Chico, the club-footed gravedigger of Bom Jesus da Mata, replied without batting an eye, "Thirty-four paupers and one infant of the bourgeoisie." How did he know? "Only one 'angel' arrived," he said, "in a proper, 'bought' coffin and only one was put into a purchased plot." The graves of all the others could be exhumed and reused for another pauperized angel within a scarce three months time. The data on class affiliation is absent on the official death certificates and so the particular social face of infant mortality and the magnitude of human suffering and loss are also erased.

Eliciting the individual reproductive life histories of poor women is a time-consuming method of investigation, but necessary not only to correct the incomplete official public record but in order to gain a deeper understanding of the context and meaning of infant death, which in rural northeast Brazil is viewed alternatively as "angel life." While the causes of infant death are largely unreported in the official vital statistics collected at the registry office in rural northeast Brazil, mothers can almost always say why a particular infant died. But since their etiological explanations bridge biological, social, political, spiritual, and magical realities, their knowledge is generally rejected by the state and by scientific investigators. The assumptions, models, and paradigms of these women do not fit the secular, biomedical, epidemiological, and demographic notions of causality, rationality, and rational choice that govern scientific research.

Nonetheless, shantytown mothers' interpretations of infant and child death can help clarify the pathogens—both microparasites and macroparasites—

which together carry off shantytown infants in veritable "die-outs": contaminated water, socially produced hunger and scarcity, unpredictable resources, exploitative "bosses," unreliable fathers, and chronic feelings of maternal "inner badness," weakness, and powerlessness. The causes of infant mortality in Bom Jesus da Mata, as the mothers readily recognized, are constitutional, economic, political, and moral/theological.

Women's reproductive histories can be supplemented by the normally overlooked knowledge, memories, and experience of children as potential informants. Children are, after all, the siblings, playmates, and not infrequently the primary caretakers of fated angel babies and even very young children can be painfully willing "informants" on the topic of child death. Twelve-year-old "China," a runaway street child in Bom Jesus, defended his knowledge and expertise as follows:

> I'm small, Tia, but I have learned a few things. I was in charge at home. It fell to me to take care of everything—the cooking, the cleaning, the shopping. You could say that I was the *dona da casa* [the madam, the woman of the household]. There were a whole bunch of us born and today there are only three of us left. I only didn't die myself because I was the oldest and I was in charge. They died of hunger and of *gasto* [weakness from explosive diarrhea]. I was expected to go out every day and find milk for the babies. . . . When they got sick it was up to me to wrap them up and carry them to the hospital. And when they died it was me who went to the mayor to ask for a coffin and it was me who arranged them in their box. It was me who got the flowers and who called the other children to make the procession to the cemetery.

In all, what is remarkable about infant mortality in northeast Brazil is its general acceptance as a fact of everyday life, and not only by *favela* women who are so accustomed to giving birth to "angel babies." Infant death has not entered the public consciousness of even rural doctors and political leaders in Bom Jesus da Mata as a serious problem about which something must be done. Shantytown infants in rural Brazil are presumed to die of "natural causes," just as old people in North America did prior to the medicalization of old age. The death of poor infants is the most natural, routine, ordinary, and even expected of events.

Letting Go—The Moral Economy of Mothering

By the time I completed my study in Bom Jesus nearly a hundred shantytown women had told me their reproductive histories, as well as their thoughts and feelings about their lives, their mostly informal marriages, and the births and deaths of their many children. The average woman of the Alto do Cruzeiro is pregnant 9.5 times and gives birth to eight living children. This, I suspect, represents an underreport of those pregnancies resulting in miscarriage or abortion as well as less-than-memorable stillbirths. Such a woman experi-

ences an average of 3.5 infant and child deaths. This profile looks very much like a classic "pre-demographic transition" pattern—a high fertility driven by "untamed" infant and child mortality.

I found that the high expectancy of child death was, indeed, a powerful shaper of reproductive and maternal thinking and practice in the shantytown, as evidenced in a conditional attachment to newborns who were often treated more like household visitors than as permanent family members. A stance of maternal watchful waiting until the baby manifested a real "hold on life" preceded the full expression of maternal love and attachment. Women's overprediction of infant death, with its accompanying distanced maternal affections, could be mortal at times and contributed to the premature death of infants who were seen as lacking a *gosto* (taste) or *jeito* (knack) for life. Such babies are described by their mothers as "wanting" or even "needing" to die.

Aided by their female relatives, neighbors, *co-madres,* midwives, and local healing women, mothers distinguished between those infants and babies who were safe to adopt into one's care and affections and those who demonstrated the will, destiny, or innate constitution of angel babies. Such babies could be assisted to die through a gradual reduction and then withdrawal of food, liquid, and care. Women sought thereby to avoid the suffering of a prolonged and agonizing death in a "little creature."

The feminist philosopher Sara Ruddick (1989) identifies a womanly attitude of "holding" as an essential feature of maternal thinking. Holding implies a metaphysical attitude of holding on, holding up, holding close, holding dear. It connotes maternal protectiveness and of conserving and valuing what is at hand. But what of mothering in an environment like the Brazilian shantytown, where the risks to child survival are legion? There, mothers must concede to a certain humility, even passivity, toward a world that is, in so many respects, beyond their control.

Consequently, among the mothers of the Brazilian shantytown, maternal thinking and practice were often guided by another, and quite opposite, metaphysical stance, one (to draw on the mothers' own choice of metaphors) of "letting go." Among the mostly Catholic women of the Alto do Cruzeiro, "letting go" implied a fundamentally religious attitude of calm and reasonable resignation to events that cannot easily be changed or overcome. It implied a leap of faith and a trust that was not easy for most poor women to achieve. The women struggled to conform to the demands that their poverty and scarcity had imposed on the practices and experience of sexuality and motherhood. "Holy indifference" in the face of terrible adversity is a cherished, though elusive, religious value. Secular anthropologists do it a disservice by reducing the phenomenon to "peasant fatalism." Meanwhile, demographers (like children) demand too much of mothers, particularly when they attribute maternal thinking and practice to alienated concepts of rational choice and to mathematical calculations concerning the value of children.

While there is something consoling in Donald Winnicott's forgiving notion of the "good enough" mother—his common sense faith in ordinary mothers to perform the requisite tasks necessary to sustain and support new life under ordinary conditions (1987)—surely "good enough" mothering depends on a "good enough" social and economic environment. And though it is rarely thought about in this way, to what extent does "good enough" mothering depend on the presence of a "good enough" baby? But favela women often speak of being "let down" and "disappointed" by their weak and sickly babies—especially those who seem to lack a certain talent for life.

The kind of thinking that evolves from the experience and practice of mothering in a context of hunger, scarcity, and infant death is somewhat analogous to the social and moral ethic of the battlefield, where triage, thinking in sets, and ideas about the magical replaceability of the missing and the dead predominate, as well as the idea of acceptable or meaningful death. In a world of great uncertainty about human life mothers may approach each new pregnancy with sorrow and dread. If an infant dies young, before it has had a chance to be properly named, baptized, or to express its individual nature, its death may be accepted as a misfortune, but not as a great tragedy. (As one shantytown father remarked when he was hesitantly told by a nurse that all had not gone well with his wife's labor and delivery, "Pois, menos um por meu poquinho de angu"—Well, less one for my little bit of gruel.) On the Alto do Cruzeiro mother love grows slowly, gradually, fearfully, increasing in strength and intensity once a mother senses that the child is not just a casual visitor to the household, stopping off on its way to the afterlife, but intends to remain and enter the *luta*, the struggle that is life.

I have encountered situations in which some impoverished shantytown mothers appear to have suspended compassion, empathy, and care toward some of their weak and sickly children, helping them to die easily and well. I spent many years trying to understand, translate, and to defend the ethical position of these folk Catholic women who refused abortion (and in some cases even birth control) on moral grounds but who confidently asserted that some of their supernumerary infants "wanted to die" so that others, including themselves, might be able to live.

I came to think of the babies of the Alto do Cruzeiro who were "given up" (i.e., offered up) and "given up on" in terms of ritual scapegoating and sacrifice as discussed by René Girard (1987). Girard builds his theory of religion around the idea of sacrificial violence and the need for an agreed-upon or surrogate victim—the "generative scapegoat"—whose suffering or death (like Jesus') helps to resolve unbearable social "tensions, conflicts, and material difficulties of all kinds" (1987:74). The given-up, offered-up angel babies of northeast Brazil were likewise sacrificed in the face of terrible conflicts about scarcity and survival. And that is, in fact, just how their mothers spoke of

them. The following theological reflection took place at a Christian "base community" meeting in the Alto do Cruzeiro in 1990:

"What does it mean to say that a baby 'has' to die, or that it dies because it 'wants' to die?" I asked.

Terezinha was the first to speak. "It means that God takes them to save *us* from suffering."

"What she means," broke in Zephinha, "is that God knows the future better than you or I. It could be that if the baby were to live he would cause much suffering in the mother. Why, he could turn out to be a thief, or a murderer, or a *cabo safado*, a good for nothing. The baby daughter could shame her family by turning out a prostitute in the *zona*. . . . And so they die instead as babies, to *save* us from great suffering, not to give us pain. Yes, there are many reasons to rejoice for the death of a baby!"

Luiza added, "Well, I only know that I kept giving birth, and mine just kept on dying. But I never gave up hope. Perhaps the first nine had to die to clear the way, to make space, so that the last five could live."

"I myself," said Fatima "don't have too much hope for this one," referring to the fussy, sickly toddler on her lap. "If God wants her, then I would be happy for her and happy for me! I would be pleased to have a little 'sacred heart' in heaven."

"But why," I persisted in asking, "would God want babies to suffer so much in dying?"

"Don't ask me," said Edite Cosmos. "I did *everything* to keep mine healthy and alive, but God just didn't want me to have them. I think that these deaths are sent by Him to punish us for the sins of the world. And yet the babies don't really deserve this. We ourselves are the sinners, *but the punishment falls on them.*"

"Be quiet, Edite," said another. "They die, just like Jesus died, to save us from suffering. Isn't that right, Sister Juliana?"

But Sister Juliana, a native of the dry *sertão* where (she said) babies did not die like flies as they did in the sugar plantation zone, was not so sure that the women were right in their moral thinking. "I don't think Jesus *wants* all your babies," she said. "I think He wants them to live." But, after all, Sister Juliana was a nun and the women of the shantytown didn't pay her too much attention. What could *she* possibly know about babies?

In searching for an appropriate, respectful way to present the existential dilemmas in the lives of these desperately poor women, who could shrug their shoulders when another hungry or dehydrated infant died and comment philosophically, "Melhor morrer menino do que um de nos mourrer" (Better that a baby die than one of us adults), I found myself walking an ethical and representational tightrope—one familiar, I imagine, to a great many anthropologists. The survivor logic that guides shantytown mothers' actions toward

some of their weak babies is understandable. But the moral and political issues still give one reason to pause, and to doubt.

In my reluctance to objectify or romanticize the women of the Alto do Cruzeiro, I avoided the easy lure of victimology and refused to see the women as merely passive victims of cruel fate, as cruel and inhuman as their material realties were. And I also refused to see them as mindlessly indoctrinated Catholics mouthing, like so many parrots, Ecclesiastical platitudes coming down to them from Rome or from the Archdiocese of Recife. These women actively made choices, as constrained as those choices were, and likewise they selected aspects of Catholic teachings that they could use or live with, while readily discarding others. Some of their moral choices—if you will excuse the pun—evidenced more than a touch of bad faith.

I think, for example, of Dona Dora's remark after she explained the folk belief in dead infants as winged angels who fly happily around the thrones of Jesus and Mary in heaven: "Well, this is what we say. This is what we tell each other. But to tell you the truth, I don't know if these stories about the afterlife are true or not. We want to believe the best for our children. How else could we stand all the suffering?" Or, I think of thirteen-year-old Xoxa instructing me on how to behave at the wake of an emaciated infant whose mother had refused to breastfeed: "You must not scold the mother. You must say how very sorry you are that Jesus came to take her baby." "Yes, of course," I replied, "but what do you think?" "Oh, Nanci! That baby never got enough to eat—but you can't *ever, ever* say that!"

The solution I eventually found was to practice what I call *antropologia-pe-no-chão*—anthropology with one's feet on the ground. The phrase refers both to an existentially, methodologically, and politically grounded practice of fieldwork, as well as to a "barefoot" anthropology which, in the language of liberation theology, means assuming "a preferential option" for the poor. I interpreted this to mean allowing myself to be drawn from time to time into local political struggles to "accompany" my Brazilian informants and friends in their daily *luta*.

The Death of Mercea: The Single Case Study

In order to secure my interpretation, I will anchor it in the narrative of the short life and death of Mercea, a three-year-old toddler from the shantytown of Alto do Cruzeiro in Bom Jesus da Mata, who died at home alone and unattended while her mother and her anthropologist were out dancing carnival in the streets. Perhaps I want to illustrate what a single instance, an "n" of 1, can contribute to demographic inquiry.

The case study, pioneered by Max Gluckman (1963) and the Manchester School of British Social Anthropology, is generally seen as a method for extracting the general from the particular (Evens 1995:17–18). Additionally, the "thickly described" case study can disclose the fundamental principles of

the given social order—the ways in which thought, ideas, and practice interact, and can illuminate the deeper meanings of social events and the moral economy which governs the resolution of a particular incident. The case study is essential for capturing the social situatedness of cultural knowledge and practice.

Three-year-old Mercea was severely ill in February 1989 and had been so since her birth at Ferreira Lima hospital in Bom Jesus. Her mother, Biu, was a forty-three-year-old cane worker, a tough woman, slight of build but with strong arms and long, thick brown hair (her one vanity) that she would pull back in a knot each morning. She rose in the dark to prepare a cup of black coffee before setting off on foot for a local plantation where she was employed with her nine-year-old son as an unregistered field worker earning less than the official minimum wage. Biu took home about $1.25 a day.

Mercea was left in the care of her thirteen-year-old sister, Xoxa, and she sat in a dark corner endlessly scratching her infected bug bites and sores. Mercea could not walk and she spoke only a few words, among which were incessant demands for fresh, unsalted meat. There had been no "Papa" in the household since the night of Sao Joao (St. John's day) when Oscar, Biu's second common law husband, walked out with the couple's gas stove, bed, and the healthiest two boys among Biu's seven surviving children (of the fifteen born to her), to live with a younger woman who, Oscar boasted, still had her teeth.

"Infants are like birds," Biu once said, "here today, gone tomorrow. Alive or dead, it's really all the same to them. They don't have that certain attachment to life of the older child." Mercea had, however, already survived over a dozen medical crises of fevers, respiratory ailments, violent diarrhea, and vomiting that had wasted her frail little body, retarded her speech, and brought her close to death. Next to Mercea's hammock was a wooden table with half-used medicine bottles, some of which, Biu said, had "worked for a while." They included antibiotics, antiseptic skin creams, cough medicines, analgesics, tranquilizers, and sleeping pills. There was even an appetite stimulant, though the child had often been denied more than a few tablespoons of "mingau" (a thin rice or manioc gruel) in a twenty-four-hour period. None of these treatments had resolved the child's main illness, which Biu described as "weakness" and "nervousness"—a *nervoso infantil*—that left her child unable to withstand the *luta*. Mercea, said Biu, never showed a real *gosto* or *jeito* for life.

Mercea was reported by her mother to suffer from periodic and violent episodes of "child attack," as women of the Alto refer to acute convulsions with head banging, eye rolling, twitching, and body rigidity. Like many women of the Alto, Biu regarded the convulsions as an early sign of incurable weakness—a precursor of what would later develop into full blown madness, epilepsy, mental retardation, or paralysis. "Such babies are never right in their head or their body." And so an antipsychotic medication that was meant for

adults and had been illegally purchased lay next to Mercea. Infants are normally allowed to die by gradually reducing food and liquids. Infant euthanasia is closer to the way shantytown women, many of them practicing Catholics, view their actions. But Mercea was too old for that sort of resolution.

Mercea's final crisis took place in the days before the Brazilian carnival when many shops and most public services were closed. Hospital staff were on strike and would not return to work until Ash Wednesday. Biu and I planned to join the revelers on the first night of carnival, but Mercea continued to have a choking cough. She could not get her breath and her little chest shook rapidly with every effort. Her skin was as dry as parchment. Biu arranged for her sixteen-year-old daughter to look after Mercea. Hospital and clinic attendants had refused to attend to the little girl in the days preceding her death; the local pharmacist sold the mother various cough medicines; and when little Mercea was in her final death throes, the municipal ambulance driver arrived too late to be of help.

The next time Biu and I met was the morning after carnival when we gathered at the home of Biu's older sister, Antonieta, to prepare Mercea's wasted little body for burial in a little painted plywood and cardboard coffin. The only official and paradoxically compassionate response to Mercea's sickness and premature death came in the form of a free pauper coffin provided by the mayor from his makeshift municipal coffin factory attached to the back of the town hall, the *prefeitura*. Biu was in shock; we had barely had time to change out of our carnival costumes. Mercea was laid out in a white Holy Communion dress and we covered her bare feet and her body up to her chin with tiny, sweet-smelling white flowers, as befitted an innocent little angel child. Mercea's uncle and her designated godfather sprinkled her still body with holy water in a ritual of conditional, postmortem baptism. No one was certain whether such a baptism would count in the after life.

Mercea's siblings and their playmates carried her light coffin to the municipal graveyard. Children bury children in many parts of Latin America. It serves, among other functions, to remove the onus from parents and to socialize children from a very early age to "death without weeping." No church ceremony marked the death, of course—300 infant and childhood deaths in a town with only 30,000 people—would be an excessive burden on the single Catholic priest. Meanwhile, the Franciscan Sisters scold women who bring them dead babies to bless rather than sick babies to be helped and possibly rescued. Only a small slip of paper from the civil registry office documents the death. The diagnosis in Mercea's case was left blank on the form. There had been no medical examination. The child had died at home, then, of "natural causes." The gravedigger chided the children for leaving Mercea's coffin lid loose. "The ants will get to your little sister," he told Leonardo, Mercea's older brother, who cried on my shoulder despite the strong cultural injunction

against shedding tears that could make the angel baby's path to heaven wet and slippery.

When Xoxa returned home from the plantation (where she was briefly employed during the carnival holiday) to learn that her little sister had died, she too grieved deeply. Xoxa was especially angry that her sister had been buried without stockings, and for several weeks she was bothered by visitations of Mercea's spirit hovering over Xoxa's canvas cot and pointing to her bruised bare feet. "She can't speak," said Xoxa, "because like all angel babies she is mute." On returning to Mercea's grave some months later to bring her a pair of stockings, we found that the area had been cleared and Mercea's space given to unfortunate twin infants. Mercea's remains had been tossed into the deep well called the "bone depository" near the west wall of the cemetery.

Vital statistics and survey research techniques conceal the existence of traditional patterns of selective neglect that only qualitative, existentially driven, and critically interpretive methods of anthropological witnessing are capable of doing and doing in such a way, moreover, as to avoid blaming women for their actions. Nonetheless, research findings continue to be fetishized, objectified, compared, and treated as if they were adequate representations of reality. Worse, they are all too readily translated into indifferent or even iatrogenic health programs and policies based on technological fixes. Among these I would cite both the Oral Rehydration Therapy program (ORT) and the decontextualized promotion of breastfeeding, both of which were supported for many years under UNICEF's international "child survival" campaign.

Misapplication One: ORT and Child Survival

Oral Rehydration Therapy, proclaimed by public health physicians as "an oasis of hope in the developing world" and as a "miracle of modern medicine," (Mull 1984) provides a case in point. The distribution of ORT sachets in communities at high risk for infant mortality is promoted on an assumption that parents everywhere share a common set of parenting goals, foremost among which is the equal value given to the survival and health of each and every child born. The child survival program assumes that once a dehydrated infant is snatched from the jaws of immediate death by a simple application of ORT, the "normal" parental nurturing, caring, and preserving instincts will resume. But where infant death is viewed as a highly probable, expected, and even beneficial outcome of birth, as it sometimes is in the shantytowns of rural northeast Brazil, and where a quarter of all babies die before the close of their first year, poor women may be unwilling to take back into the family an infant already perceived as "giving up" and "given up on." Consequently, I have had the bad fortune to see scores of shantytown babies rescued with ORT and antibiotics half a dozen times or more in the first year of their lives, only to die

of chronic diarrhea, wasting, and respiratory ailments after the seventh or eighth medical rescue.

The distribution of ORT sachets does not take into account polluted water supplies, nor does it anticipate local perceptions of the salts as a powerful medicinal infant food that requires little supplementation. Babies raised on ORT, like babies raised on watery "pap," will often die on it. ORT is not a substitute for breast milk, clean water, attentive nurturing, appropriate medical care, adequate housing, fair wages, free and universal public education, or sexual equality, all of which are prerequisites for child survival.

In this instance, is ORT a life-affirming or death-prolonging intervention?

Over the years that I observed Biu and her family, Mercea received ORT on several occasions. She was brought to clinics and immunized against most communicable diseases. She was treated for worms. The apparent pneumonia from which she died in acute distress (the "acute infantile suffering" listed in the death certificates of the civil registry office now begin to take on a human face) was perhaps, as Biu eventually came to see it, a blessing in disguise. Mercea's escape from chronic hunger and sickness would require far more than any technological fix could possibly offer. The child's rescue could not be accomplished without the simultaneous rescue of her mother and other siblings. And the rescue of Biu and her other children depended, in part, on the rescue of her alienated husband, Oscar, whose state of permanent economic humiliation kept him running from household to household in shame. Oscar's poverty made him a promiscuous father and a deadbeat husband. The rescue of Oscar and all the other great-great-great grandsons of plantation slaves throughout the world depends on a realignment of North-South relations and of the capitalist global economy, no matter how naive and counter-intuitive this may seem at the close of the twentieth century.

Misapplication Two: Mother's Milk and Infant Death

A fairly direct correlation has been established through conventional empirical research between infant survival and breastfeeding and between infant death and bottle feeding in the Third World. Yet it is also widely documented that each generation of new mothers in the Third World is less likely to nurse their offspring than the previous generation. More than a decade ago UNICEF (1983) reported the percentage of babies breastfed for any length of time in Brazil had fallen from 96 percent in the 1940s to under 40 percent in the 1970s. This phenomenon was especially marked among rural migrants to urban areas, where wage labor displaces home economies and cottage industries more compatible with breastfeeding and puts a plastic wedge between mother and infant and between infant and breast.

The staple food for the infants of women working for wages is reconstituted powdered milk extended with a starch filler and sweetened with sugar. A great many poor women cannot afford sufficient quantities of commercial

powdered milk to satisfy the baby's hunger, in which case they increase the starch and sugar or they eliminate the expensive powdered milk entirely and feed their infants a watery gruel called *papa d'agua.* Their babies readily sicken and die on it.

Why is this irrational practice maintained in the face of such graphic failure? Why did poor women so readily give up the breast for the commerciogenic bottle and powdered milk? How were they turned into consumers of a product that they do not need, cannot afford, and that contributes so directly to the death of their infants? Empirical studies and survey research, including a study sponsored by the World Health Organization of infant feeding patterns in nine countries (see Gussler and Briesmeister 1980), indicated that worldwide the most common explanation given by women for discontinuing breastfeeding was "insufficient milk." This finding led to many unfounded arguments about the biological fragility of breastfeeding as a practice (including height-weight-body fat and other nutritional correlates of successful breastfeeding). In fact, breastfeeding is bio-evolutionarily protected, and even very skinny and malnourished women—not to mention famished women—can adequately breastfeed a young infant. Saying this does not, however, suggest a lack of empathy for the individual and often nutritionally battered bodies of women.

One thing is certain. Mother's milk assumes new cultural and symbolic meanings wherever subsistence economies have been replaced by wage labor. The culture of breastfeeding was lost over a very rapid period in modern northeast Brazilian sugar plantation life. What had changed radically was poor women's beliefs in the essential goodness of what comes out of their own bodies, which they now saw as dirty, disorganized and diseased, as compared to what comes out of clean, healthy, modern objects, like cans of Nestle's infant formula, clinic hypodermic needles, and rehydration tubes.

Moreover, in terms of the bricolage that governs family formation in the shantytowns of Brazil, the ritual that creates social fatherhood today relocates baby's milk from mother's breasts—disdained by responsible, loving women—to the pretty cans of powdered milk formula (bearing corporate and state warnings about the dangers of the product that these illiterate women cannot read), which are carried into the shacks and shanties of the Brazilian *favela* by responsible, loving men. Paternity is transacted today through the gift of "male milk"—Nestle's powdered milk. Father's milk, not his semen, is a poor man's means of conferring paternity and of symbolically establishing the legitimacy of the child.

A new mother on the Alto do Cruzeiro will delightedly say when her boyfriend appears on her doorstep carrying the weekly requisite can of powdered milk, "Clap your hands, baby! Clap your hands! Your milk has arrived!" Conversely, the woman whose breasts flow with milk and who sustains her infant from them is, symbolically speaking, the rejected and abandoned woman, the

woman whose baby has no father. For a woman to declare that she has no milk, that she has very little milk, or that her milk is weak and watery may be a proud assertion that both she and her baby have been claimed and are being nurtured by a protective male mother, a milk-giving father. All the UNICEF sponsored posters and classes and ads promoting the "obvious" benefits of maternal breastfeeding cannot turn around this new practice which has transformed gender and generativity in such profoundly modern and technological ways.

Toward a Demography beyond Numbers

At the heart of the anthropological method is the practice of witnessing, which requires an engaged immersion, as far as possible, in the lived phenomenological worlds of anthropology's subjects. Looking, touching, seeing, feeling and reflecting with people on the key experiences and moral dilemmas of their lives—and our own lives with them—as these are happening in the field constitutes the method of participant-observation—a method that is hard to categorize and harder still to teach. This always flawed, human encounter demands that the researcher take stands, make mistakes, move in, pull back, and move in again. In northeast Brazil it meant living with and absorbing the protective guise of indifference to hunger and death until I could not stand it any more and allowed the repressed horror to return. Witnessing means taking people at their word sometimes and second guessing them at others. It means keeping an open dialogue with people who are just as morally conflicted and challenged and horrified, by turns. It means, above all, not standing above and outside the fray, coolly observing and recording objective facts and turning these into scientific models which are nothing of the sort, and never were.

Against this "little tradition" and "minor practice" of traditional humanistic and engaged anthropology are arrayed all the mighty forces and guns of high-powered and high-tech scientific research. The basic quantitative methods of demography and epidemiology were introduced to Brazil in the 1960s through large grants from North American foundations, including the Ford Foundation and the MacArthur Foundation. These grants have established academic departments as well as doctoral and postdoctoral training programs which have produced by now an almost unassailable tradition of scientific positivism. Demography in particular has assumed enormous power and influence in the formation of social and government policy and programs in Brazil, Mexico, India, and elsewhere in what used to be called the "developing" world. We might begin by interrogating the particular political and economic history that has lead to the dominance of these approaches and traditions of research and the status of their "objective" measures of health and well-being, as Arjun Appadurai (1991) has done for colonial India and David Armstrong (1986) has done for late-nineteenth-century medicine in Britain.

We are today so accustomed to thinking that official and government policies can only be built around hard data—an accumulation of neutral and objective facts and on statistical figures and flow charts—that we can scarce imagine serious public policies and programs emerging from in-depth case studies or from interpretive analyses and moral-philosophical arguments. But until very recently in the United States and elsewhere, public policies were argued and decisions were reached by relying on historical, ethical, and philosophical arguments, while facts, figures, statistics, and other quantitative measures were used, if at all, as supporting evidence. Quantitative data were not expected to argue the final case as they so often do today.

Although its influence has been stunted in the late twentieth century, interpretive research has introduced human rights and ethical concerns into various scientific research programs and agendas. Culturally sensitive, qualitative, ethnographic research on reproduction and population issues in India, Africa, and Latin America clarified very early on the crucial difference between family planning and population control and revealed the tensions between the individual good and the common good as these were socially constructed within different polities (Polgar 1976; Mamdani 1967). Thanks to qualitative, interpretive research, the ethical considerations and the cultural appropriateness of various kinds of governmental interventions are now being explored in philosophical and moral-political language. Calls for research and new policy initiatives by the World Health Organization, the MacArthur Foundation, and the Ford Foundation, among other research funding giants, are beginning to affirm and to promote reproductive rights, women's rights, and broader issues of social and political equity (Martine 1990; Ford Foundation 1991; Scheper-Hughes et al. 1991). For example, in 1992–94 the Ford Foundation office in Rio de Janeiro sponsored a critically applied research program on "AIDS, Women, and Reproductive Rights" (Scheper-Hughes et al. 1991) that attempted to discover ways to bring the particular reproductive issues of women to bear on a grassroots AIDS education and prevention program, which was until then focused almost exclusively on "condom literacy" (Scheper-Hughes 1994b; Goldstein 1994).[3]

Obviously, what I am calling epidemiology and demography without numbers requires anthropologists who are free agents and who will not work as handmaidens to medicine, the biomedical sciences, or the statistical demographic sciences in a dependent and/or auxiliary capacity.[4] There is really no need for more collaborations between qualitatively-trained anthropologists and epidemiologists or demographers in which the realm of the social is reduced to a set of reified and lifeless variables. The piling up of quantitative data that relies on biomedical and Western categories will not generate fresh insights. Instead, a praxis-oriented, critically applied, and politically engaged anthropology is needed to illuminate the complex and multifaceted existential, cultural, medical, moral, and political dilemmas of vulnerable popula-

tions such as those confronting shantytown women and children in Brazil. Critically interpretive research begins with a series of negative questions: What is being hidden from view in the official statistics? Whose economic or political interests are reflected in the kinds of records kept? How are the records kept? What events are tracked? What is thought hardly worth counting at all? And what can this tell us about the collective invisibility of certain groups and classes of people—women and small children in particular? Only a paradigm shift toward a theoretically-driven and critically interpretive and analytical work can open up new areas of knowledge about the relationship between the way people live and the way they die.

NOTES

1. There is an anecdote that goes with this title which in its self-mocking may undercut whatever expertise I might claim from the outset. In the spring of 1979 a Brazilian psychiatrist studying for his doctorate in social epidemiology at the University of North Carolina, Chapel Hill came to my seminar in research methods in medical anthropology. Dr. Almeida Filho enthusiastically presented me with several dozen fairly complicated quantitative computer printouts related to his study of mental health and migration in Salvador, Bahia. After poring over the printouts with him—and finding much that I could not follow in his statistical formulas—I said (to his shock and embarrassed confusion), "I can't help you; you had better discuss these with a statistician." "Oh, excuse me," he replied, "I thought you were a kind of social epidemiologist." "I am," I replied, "but an epidemiologist . . . without numbers!" As Dr. Almeida Filho himself became more concerned with philosophical, qualitative, and theoretical issues in social epidemiology and medical anthropology, he found time to write an excellent monograph on the central problem of the object in epidemiological studies, arguing that what is constituted as the object of knowledge overdetermines the method of investigation. The title of his book, which I have now adapted for this chapter, is *Epidemiologia sem Numeros*—Epidemiology without Numbers.

2. Excellent reviews of this intellectual history can be found in Habermas 1968; Rabinow and Sullivan 1979; Rorty 1979; see also Megill 1991.

3. Goldstein and I tried to persuade grassroots activists and medical workers that the current AIDS education programs, based as they were on phallocentric assumptions and fairly universal notions of what I call basic sexual citizenship, were incapable of protecting poor women and other sexually vulnerable groups. Poor women and other "classificatory females" (i.e., "sexual passives" within the Brazilian sex/gender domain), such as street children and female transvestites, lacked the phallus and therefore the ability to make rational sexual choices or the power to control the transgressive autonomy of those who possessed the phallus (see Scheper-Hughes 1994b). Goldstein (1994) suggested that the sexual transmission of HIV hinged on this hitherto rejected knowledge in the present climate of male and exclusively "sex positive" AIDS activist discourse.

4. I expand this point elsewhere arguing that critically applied medical anthropologists need to establish greater distance from the centers and sources of biomedicine and bio-power and to assume a role of voluntary marginality—and voluntary poverty shall follow! Medical anthropology can provide "that small, sometimes mocking, often

ironic, but always mischievous voice from the sidelines . . . afflicting the comfortable, and living anthropology as the 'difficult science'" (Scheper-Hughes 1990:195).

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