Politics, Practical Logic, and Primary Health Care in Rural Haiti

During the 1980s, an ambitious project for health development restructured medical services throughout rural Haiti. The "Rural Health Delivery System" (RHDS) pursued several goals of primary health care, including dispensary-based maternal and child health services and the provision of low-cost drugs. Based on fieldwork in a single village, this article examines how local residents pushed the project in unpredictable and ironic directions. People did not regard dispensary services—which were planned and financed by international health agencies—as essentially foreign elements in the local health-care system. They rather engaged with the dispensary according to long-standing local strategies for prestige and economic advance. Despite the dramatically new shape of biomedicine introduced by the RHDS, the dispensary remained for most people a recognizable arena to gain access to state resources or to contest state control over their lives. The "success" of clinic services, and the "failure" of the project to distribute essential drugs arose more from people's practical routes to symbolic and material power than from the formal plans of health planners or state bureaucrats. This practice-based analysis provides another dimension to both the liberal and neo-Marxist critiques of international health development.

This article rethinks some central theoretical questions in the anthropological study of primary health-care projects, currently the major form of planned development in international health. Based on fieldwork begun in 1987, the article documents the long-term consequences in a single Haitian village of a massive multilateral program in rural primary health care (PHC). It shows why particular aspects of this program succeeded or failed, in view of the project's stated goals. However, it also explores how residents' practical strategies for prestige and material advance pushed formal "development" plans in unpredictable and contra-
dictory directions. The approach taken here departs from conventional anthropological critiques of PHC projects. The apparent failures of this program were not due to the cultural distance between local health beliefs and imported biomedical notions of illness and healing. The program was not a vehicle for Western hegemony or neocolonial control, and it was not thereby essentially hostile to the structural changes demanded by PHC rhetoric. The mission here is not to determine whether the project was ultimately harmful or beneficial to rural residents (see Heyer et al. 1981). The article instead traces the ultimate fate of this public health project to villagers' competing routes to symbolic, material, and political power.

In the small market town of Jeanty in southern Haiti, the eventual shape of planned primary health-care services arose from people's short-term maneuvers in the face of novel and shifting opportunities. These maneuvers had a double effect, which requires a double-edged analysis. On the one hand, people engaged with particular PHC initiatives through well-known, local strategies for reputation and personal advance. As a result, these pre-existing strategies were confirmed as sensible and effective ways of acting in the world. On the other hand, the material and symbolic power introduced by this PHC project destabilized local practices. People were forced to innovate in response to these new resources, and their innovations helped transform the texture of rural social life. This case study focuses on the unintended and contradictory effects of this PHC project—how people used it both to reproduce and to transform local cultural traditions—and thus suggests the need for anthropologists of international health development to attend to local forms of practical logic.

The Rural Health Delivery System (RHDS) project, lasting officially from 1980 to 1985, was an ambitious attempt to restructure public medical services in rural Haiti according to the ideal of universally accessible primary health care. It incorporated many of the recommendations for international health issued by the Alma Ata declaration (Taylor 1979): recruiting community health workers from villages; providing comprehensive, low-cost, preventive services (nutrition, family planning, prenatal and postnatal care, and immunization); and establishing a self-financing network of community pharmacies to sell low-cost, essential drugs to dispensary patients (Bates 1985; Lerebours and Rohde 1985; Rohde 1986).

Through a collaboration between the Haitian Department of Public Health and Population and USAID (which supported it with a $35 million budget), the RHDS project transformed the shape of biomedicine throughout the countryside. I saw the long-term effects firsthand in Jeanty during a larger study of medical pluralism and religious healing (see Brodwin 1996). The pattern of RHDS "successes" and "failures" in Jeanty was easy enough to document. But to explain what produced them, we must first review two well-known approaches for the anthropological study of international health development.

These two approaches—the liberal "health beliefs" model and the neo-Marxist "political economy" model—are invoked in different ways in the case studies and reviews that make up this vast literature (for collections of case studies, see Bloom and Reid 1984; Coreil and Mull 1990; Nichter and Nichter 1989; Rifkin and Walt 1988; for major review articles, see Foster 1984; Heggenhougen 1984, 1993; Pillsbury 1985; Rubenstein and Lane 1990). What follows is obviously not a comprehensive overview of PHC but rather a survey of how the concepts of culture
and agency have been used in this literature. The survey offers a reorientation for future work, based on the suggestions of Paul and Demarest (1984), Stone (1989), and others, which is then applied to the RHDS project in Jeanty.  

Beliefs, Politics, and Practical Logic in Health Development

The health-beliefs model focuses on the cultural distance separating outside development planners from the people they plan for, especially in their divergent notions of the body, illness, and health care. The political economy model takes a more ironic stance and critically evaluates the distance between the inclusive, participatory rhetoric of PHC and the actual results of particular PHC programs. While powerful in their own right, both of these models downplay the practical perspective of the people who are most affected by PHC projects. In the first model, local residents are the supposed beneficiaries of improved services; in the second model, they are the ultimate victims of a repressive social order that co-opts PHC programs (Green 1989). However, people’s own attempts to appropriate the resources introduced by PHC projects are rarely examined. This limitation reflects both the history of anthropologists’ involvement in international health and the particular notions of culture and agency that they use.

During the formative period of their field, medical anthropologists became culture brokers who addressed both parties in international public health projects (cf. Foster 1984; Mull 1990). In one direction, they analyzed local illness beliefs—grounded in “traditional values, institutions, and practices”—that supposedly prevented people from accepting the Western-designed public health interventions (cf. Hoben 1982). In the other direction, they criticized the naivete and arrogance of public health planners who assumed that Western biomedical therapies, empiricist views of disease, and vertical programs of health services would be automatically accepted by all communities (Good 1994:26; see Polgar 1963).

The dominant anthropological model that arose in this period considers local illness beliefs as false propositions compared to the truths of biomedicine (Good 1994:39ff). Nonetheless, these supposedly inaccurate beliefs give rise to stable norms for health-related behavior. For example, allegiance to traditional notions of disease-carrying spirits led Chinese villagers to ignore or vastly underutilize biomedical services during a cholera epidemic (Hsu 1955). The Nichters invoked essentially the same model of cultural beliefs in a paper published 37 years later. Ethnophysiological beliefs about fertility and menstruation in Sri Lanka and South India, couched in metaphors drawn from agriculture or kinship, contradicted the biomedical model and thus posed thorny problems for health education about family planning (Nichter and Nichter 1987).

Of course, these two generations of anthropologists draw vastly different implications from the gap between traditional and biomedical beliefs (usually clustered into more comprehensive “belief systems”). The earlier adversarial model portrayed the two systems as mutually exclusive (see Foster 1977). The mission to correct presumably false beliefs has given way to sensitive attempts to negotiate between the two cultural worlds and craft the health-education messages recommended by biomedical science in appropriate, locally acceptable idioms (Nichter and Nichter 1989). But the fundamental analytic strategy remains the same: to gauge the distance between local illness beliefs and the scientific principles under-
lying public health interventions. This core task remains as important for the preventive and behavioral focus of PHC as it was for the single-problem technical interventions of the 1950s and 1960s (see below).

A representational notion of culture underlies this model. Health beliefs are propositions about the empirical world—the body and bodily disorder—however much they are couched in local symbolic idioms. This model also features a cognitive and utilitarian notion of human agency. It assumes that people act rationally toward the goal of positive health. In its most formal and elaborate version (the Health Beliefs Model devised by social psychologists in the 1950s), people calculate their susceptibility to and the severity of specific illnesses and then decide on a particular course of action based on its perceived benefits and barriers (Rosenstock 1974). People thus engage PHC initiatives with a cost/benefit calculus, and this allegedly informs, for example, Haitian mothers’ use of free immunization services (Coreil et al. 1989) and Indian mothers’ decisions to consult trained traditional birth attendants (Stephens 1992). Although few anthropologists would accept all of the assumptions of the original Health Beliefs Model, they still investigate chiefly the cognitive maps that guide decision-making about PHC. For example, the Nichters use a method of education by appropriate analogy, in which people are motivated to adopt certain kinds of health behavior by broad metaphors and indigenous idioms (Nichter and Nichter 1989).

This approach also comes with a distinct ideological commitment: the liberal reformist position that health development provides practical and apolitical tools for solving specific human problems. Anthropology, in this model, is a form of policy science that evaluates projects and suggests ways to improve them. Justice’s research in Nepal is exemplary; she provides background cultural knowledge relevant to specific programs for training rural health workers and reorganizing primary-care services (Justice 1984, 1986). When the national health bureaucracy ignored her findings, Justice simply pursued the original goal at a higher level by investigating the culture of health bureaucrats, which inhibits innovation even when accurate ethnographic information is available (Justice 1987). (A similar move is made by MacLean and Bannerman 1982.)

The second model for the anthropology of international health has a very different ideological commitment. This model claims that PHC projects by necessity challenge the political status quo, and that dominant groups will most often appropriate the resources committed to such projects in order to ensure their failure. For example, Whiteford (1990) argues that PHC became institutionalized in the Dominican Republic as part of a larger strategy of control by the United States. From its inception, PHC in this country aimed at strengthening a dependent pro-American regime, not at improving people’s health. Although PHC rhetoric may have a strong egalitarian and progressive bent, actual PHC projects, once they are implemented, usually buttress the established political order (see Morgan 1989).

This second approach adopts the neo-Marxist position that international health development actually “underdevelops” health, and that many projects do little more than advance the imperialist control and exploitation of peripheral areas (Elling 1981; Escobar 1991). It deploys anthropological research as a critique of dominant reformist ideology, to expose, for example, the crypto-conservative approach of PHC bureaucrats who ignore the political roots of poor health and exclude grass-
roots social struggles from their formal development plans (e.g., Morgan 1993). The persistence of poor health among recipients of PHC projects is not due to the planner’s insufficient cultural knowledge, but rather the larger inequitable social and property relations that planners willfully ignore (see Gish 1979).

Instead of a propositional model of cultural knowledge, the second approach privileges a conflict-ridden model of social action. Cultural beliefs are resources that people utilize to address the major social and economic contradictions affecting their lives (Singer et al. 1988). Instead of assuming that cultures exist as discrete, bounded wholes, each with its own medical beliefs, this model links together isolated villages, national elites, and international health bureaucracies in webs of political influence. Uncovering relations of power and domination, often hidden by appealing rhetoric about community participation, is the main intellectual strategy of this approach.3

This model privileges the relationship of cultural categories to wider fields of force, and health-related activities are understood in terms of their place within larger political contests. This approach asks how the ambiguities of behavior and identity are exploited by groups with conflicting interests (e.g., the village health promoter appears to his/her neighbor as an “advocate for the community” but to the national elite as a “traitor”). The notion of agency here is explicitly political in the obvious sense: actions that strengthen or oppose overt forms of domination. People’s motives grow not from ahistorical conceptual structures or a utilitarian calculus, but rather from the inequalities and forms of mystification in society as a whole. Finally, the agency of particular actors is located in a national and international network of power. (For other Caribbean examples, see Marchione 1984 and Singer et al. 1988.)

The health beliefs and the political economy models do not exhaust the anthropological study of PHC projects. The preventive and curative services of PHC represent something more than aids to better health or vehicles to extend (or contest) the power of elite groups. They are also symbolic and material resources for which people compete in pursuit of local goals that may have little to do with health status or national politics. The resources introduced by PHC projects enter the long-term processes of social reproduction and transformation in a given setting. Such projects are taken up by people who possess a practical mastery of the local routes to economic advancement and cultural prestige. The criteria for success devised by outside experts—development planners and anthropologists alike—often ignore the insider’s practical perspective. In this sense, PHC projects have considerable unintended consequences that anthropologists should look at more systematically.

These unintended consequences are especially striking when the emphasis on grassroots participation in PHC projects runs up against the deep factionalism in particular communities. For example, Paul and Demarest (1984) describe how political and religious divisions frustrated plans to form a “representative committee” to oversee the PHC clinic in a Guatemalan village. Because the project promised valuable resources, long-standing factions competed for its control and undercut each other’s efforts. The planners’ scheme for democratic “community involvement” was thus irrelevant to the local social field, where people acted according to an entirely different logic of political mobilization and influence. This
Guatemalan case is hardly unique: PHC initiatives are radically recast within local hierarchies and forms of political control throughout the world (see Walt et al. 1989 on the selection of CHW's in Sri Lanka, and Freund 1991 on the failure of community support for PHC in Zambia).

Analyzing PHC projects thus demands a practice-based approach that unfolds from within the same horizons of understanding occupied by the intended recipients of aid.4 This approach should take seriously the opportunities and threats posed by PHC projects not only to the recipients' health, but also to their social position and their access to other forms of material and symbolic value. This approach should examine the pragmatic logic by which people engage with PHC projects according to the goals that they find most compelling. For example, to study community participation from this angle, we would not evaluate it according to the planner's criteria of equality and community self-reliance (see Stone 1989), and we would not aim at a multilevel synthesis of local, regional, and international development activities. We would rather ask how people apply a pre-existing repertoire of effective action to new opportunities and thereby refigure the project's possibilities in terms of multiple local agendas. Although open-ended, this focus on practical logic examines primarily new forms of prestige, new opportunities for advance, and new types of relationships that PHC projects introduce between medical providers and patients. The ultimate goal is to show how people recalibrate their local practices to these new resources (cf. Bourdieu 1977, 1990).

To illustrate these ideas, the following study of the RHDS project focuses on the ironic and contradictory result of people's struggles over PHC resources. The analysis does not treat international health development either as a benevolent force (to be reformed) or an exploitive power (to be denounced) (Ferguson 1990:14). Instead, it suggests how people's short-term moves toward greater prestige or material advance pushed the RHDS project in unpredictable directions. As much as possible, the analysis is formulated in terms of the multiple and often competing perspectives of residents from the village of Jeanty. The case begins with the national and regional context of the RHDS scheme but then moves to Jeanty and examines (1) the ways people structure social life in the dispensary and (2) their struggles to control the RHDS-sponsored "community pharmacy."

Planning for Health: The Rural Health Delivery System

The present dispensary in Jeanty was built in 1976 by the local French priest, Père Joseph, although he soon gave it to the Haitian Department of Public Health and Population (Département de la Santé Publique et Population, or DSPP). People list the dispensary along with the other improvements he provided to the parish, which have added significantly to local economic activity. Although the population of the village itself is only about 3,000, it has become a magnet for people who live in scattered hamlets throughout the parish. They come to sell their produce at the twice-weekly market, to have their babies immunized at the dispensary, to attend mass at the official Catholic church of the parish, or to get a few years of secondary education. These village institutions represent the lowest tier of the various formal and informal hierarchies in Haiti. Their location in Jeanty, as the largest village in the parish, makes it relatively wealthier than neighboring hamlets. Nonetheless, for the peasants and petty tradespeople who live there, the path of upward mobility
requires leaving the village and working in Les Cayes and Port-au-Prince or immigrating to the United States. Even for routine medical care, people who can afford it prefer to attend the clinics operated by the Catholics or Baptists in nearby towns.

By the early 1980s, the DSPP health services in Jeanty were run down, poorly utilized, and lacking supplies—a typical situation in rural Haiti that the Rural Health Delivery System (RHDS) project explicitly tried to reverse (Rohde 1986). The RHDS program was an ambitious example of planned development in a liberal and postimperialist vein (cf. Robertson 1984). It explicitly advanced preventive care in rural areas and involved a cadre of (mostly American) economic and managerial advisors who worked directly with their Haitian counterparts. In the words of its American director, the RHDS project was a classic example of infrastructure development, in which project personnel (USAID staff, consultants, and Haitian technocrats and physicians) introduced North American administrative and management tools to the “underdeveloped” DSPP bureaucracy (Rohde 1986:149). However, these individuals also communicated emergent trends in international health and then supervised their translation into particular programs. These programs included a network of rural dispensaries staffed by trained health workers who also collaborated with nonbiomedical healers (primarily midwives); a schedule of weekly prenatal and postnatal clinics, supported by a reliable supply of low-cost pharmaceuticals (DSPP 1983); and a new decentralized mission for the state health bureaucracy. The DSPP had long given urban-based curative services much higher priority than preventive care in rural areas, and the RHDS project changed this priority by building rural clinics and extending the administrative and technical reach of the DSPP into isolated villages. In keeping with the liberal reformism of contemporary international development and the specific policies of comprehensive and selective primary health care (see Walsh and Warren 1979), the RHDS rhetoric emphasized the equitable distribution of resources and the cost-effective provision of preventive care.

The RHDS project thus brought activities in the Jeanty dispensary under the influence of decisions made by health planners in both Port-au-Prince and Washington, DC. However, this model of benign top-down influence is wholly inadequate to describe villagers’ response to RHDS initiatives. Although biomedicine in Jeanty in the late 1980s was profoundly influenced by this project, its influence was impossible to predict from the planners’ intentions. In the planners’ rhetoric, the project transferred resources and clinical directives from the developed world to isolated rural communities. However, the routine interactions in the dispensary were produced not only by formal plans from above but also by the micro-politics of deference characteristic of dominant village institutions other than the dispensary. Moreover, villagers criticize the RHDS project not so much for weakening the village vis-à-vis the state, but rather for the way it allowed a few local villagers to gain control of the new RHDS-introduced resources for their personal advance. Only by examining people’s practical strategies to circumvent or take control of the symbolic and material resources of the RHDS project can we explain how it reconstructed biomedical services in Jeanty.
Deference and Authority in the Jeanty Dispensary

The RHDS project linked Jeanty to centralized political power in Port-au-Prince as part of a formal pyramidal plan that encompassed the entire nation. The dispensary that already existed in the village was conceptually inserted into a nation-wide hierarchy as a bureaucratically defined unit equal to all others at the same level (Bisaillon 1988). Operating in a rationalized and featureless national space, the DSPP could not calibrate its programs to unique local needs or conditions, and it could not direct how the resources it introduced would eventually be used. Nonetheless, it attempted to exert administrative control through formal guidelines for both medical services and personnel that were still in place by the late 1980s.5

The RHDS project determined the current makeup of the medical staff in Jeanty: a resident nurse, two nurse auxiliaries, a visiting physician (who rarely appears), and four community health workers. The schedule of pediatric and prenatal clinics also conforms to the priorities laid out in RHDS documents. The dispensary staff follows a standard set of administrative procedures for every villager who requests care,6 and the pervasive bureaucratic organization of clinical work is largely the result of RHDS reforms.

All of the printed forms used in these routines are provided by the DSPP, and these forms clearly define the necessary and sufficient steps in patient care. The dispensary staff actually relies on them in order to process a large number of anonymous patients through the mandated clinical procedures. The forms not only provide minimal criteria for clinical work, they also enforce the social control of the centralized DSPP bureaucracy over this peripheral clinic, since the staff’s salary depends on the timely submission of monthly reports to the regional DSPP office. Moreover, because most patients are illiterate, they rarely understand either the meaning of or need for the forms; these omnipresent bureaucratic procedures thus remain opaque to most villagers.

On a formal level, the RHDS project laid down a template for biomedical services that satisfies the administrative needs of the DSPP in Port-au-Prince but that seems entirely foreign to the texture of local social life. On a practical level, however, both dispensary personnel and patients have assimilated interactions in the clinic to specific cultural models of behavior appropriate to other arenas of village life. “Cultural model” here means not an abstract symbolic structure, but rather the mutual expectations and taken-for-granted rules that pattern unfolding activities in a predictable way. This model involves an intersubjective schema that is shared among all villagers and that guides acceptable behavior in several other public settings besides the dispensary (see D’Andrade 1990:101). This local code of deference structures social life in the Jeanty dispensary as much as the bureaucratic procedures imposed from above.7

The authoritarian structure of staff-client relationships is the major dimension of this conventional script for behavior. Villagers do not expect dispensary personnel to treat them as equals. They conform to the endless bureaucratic procedures with only rare complaint. They routinely defer to the staff’s medical judgments, and they offer little resistance to the embarrassing public criticism that staff employ to instruct other villagers in hygiene and nutrition. But their deference is not produced by a foreign code that has replaced local rules of behavior. To the
contrary, people have assimilated the dispensary, as a bounded social arena, to several other hierarchical institutions in Jeanty, particularly the schools and the civil court, where villagers petition representatives of dominant national institutions for needed services.

Conforming to this code of deference, the staff exerts nearly exclusive control over the rate of clinical work. Patients usually sit on the wooden benches waiting for one of the auxiliaries to notice them. It is exceedingly rare for a patient to interrupt a staff-member and ask directly for a consultation. Moreover, most people do not come prepared with a story of their illness to tell to the dispensary staff but instead expect the staff to take the initiative and give them a physical exam and prescription for medication.

Moreover, the nursing staff may relentlessly criticize patients in the waiting room. This public teasing and shaming are silently endured by the patient who has been made an instructional example to the others. During the pediatric clinic, for example, one of the auxiliaries approached a sickly girl sitting with her mother. When she lifted up the child's straw hat to reveal her hair, red and thinning from malnutrition, she exclaimed, "Look at that, she's malnourished! You don't have to give her medicine, just give her good food, food that nourishes her body: vegetables, juice, carrots." Both auxiliaries then delivered a vehement and even angry explanation about the importance of good nutrition that lasted at least 10 minutes. The woman seemed acutely uncomfortable and weakly offered a few inaudible words in her defense as everyone else in the waiting room looked on.

Another striking instance of public shaming took place in the waiting room during the prenatal clinic. An auxiliary was filling out the prenatal chart for a young woman wearing a new fashionable pink dress with matching hat. The nurse walked out of her office and immediately began to tease her in front of the other expectant mothers: "Oh, you're looking pretty stylish today. This isn't how a pregnant woman should dress, with such a tight belt; your baby can't even breathe!" The woman smiled in embarrassment and the nurse turned to a younger woman wearing a tight turquoise dress. She continued her lesson: "Why are you wearing this dress? You don't want people to think you're pregnant? How old are you, anyway? Fifteen years?" The young woman gazed downward and muttered, "I'm seventeen." The nurse turned on her heels to face the two auxiliaries and said in a loud voice, "Oh, look at the child who's already having children of her own!"

Why do people accept this teasing with at most an embarrassed glance at other patients? Although the aggressive verbal give-and-take typical of the marketplace is absent here in the dispensary, these women have not in their virtual silence abandoned a local code of behavior for some foreign norm of medical interactions. They are instead following a well-known code of deference already enforced by the other institutions where villagers interact with local representatives of supralocal bureaucracies. For example, in both schools and the dispensary, villagers do not contest the superior knowledge of those who instruct them. The pedagogy employed in the local elementary and secondary schools treats students as passive recipients of knowledge. Most subjects are taught by rote, and until the early 1980s, the schools utilized French as the language of instruction, although no child raised in Jeanty can speak or understand French very well. They therefore spend hours after school repeating their lessons out loud, as they attempt to memorize them with
little comprehension. In the dispensary, of course, everybody speaks Creole. But patients pay the same unquestioning respect to the dispensary staff as they do to teachers, and they rarely challenge even the harshest criticisms about their appearance, their children’s health, the foods they eat, and so on.

Social relations in the dispensary also closely mimic the deference and respect for hierarchy typical of the Jeanty Tribunal (civil court). In both settings, villagers appear as petitioners who address their request to experts whose cultural authority and social power remain largely unquestioned. The tribunal, staffed by a justice of the peace (a high-status villager), features a large public waiting room where most individual cases are heard. As in the dispensary, villagers wait patiently until the judge calls their name and hears their complaint or request. Dispositions are usually rendered on the spot and in public: like the majority of medical interventions, the settlement of legal disputes is afforded little privacy. The final decisions rendered by the judge, like the moralizing public health lessons delivered by the nurses, are not open for debate, and in both cases the authorized experts retain uncontested control over the pace of work.

These comparisons show that the RHDS project did not arrive here like a juggernaut, imposing an essentially foreign set of social relations on those who seek care. People have instead reconstructed the social relations in the dispensary according to the same codes of behavior appropriate to the schools and in civil court. Despite the foreign origins of specific RHDS clinical directives, the social relations of clinic-based medicine was quickly localized: not to villagers’ “cultural beliefs,” but to the pattern of dependence on powerful national institutions that characterizes much of social life in rural Haiti. The dispensary is thus no more hegemonic or intimidating to villagers than their own schools and courts. It is probably no less hegemonic or intimidating, but that is precisely the point. People regard the dispensary as yet another site where local representatives of powerful outside forces provide highly valued resources and techniques for ordering life.

In the dispensary, as in school classrooms and the civil court, residents of Jeanty enter as relatively passive clients at the bottom of a national hierarchy, which has derived its legitimacy from far outside the village itself. To gain the rewards offered in these settings (such as certification to advance to secondary school), villagers must follow certain codes of deference (such as accepting the teachers’ authority and speaking only French). Patients submit to the interminable bureaucratized procedures and public shaming with similar motivations. They thus reproduce the social relations typically found in the interface between formal national institutions and members of the rural or urban poor in Haiti: social relations that are formal, authoritarian, and partially inscrutable to the petitioners from below.

Contests over Profits: RHDS and the Pharmaceutical Market

Both residents of Jeanty and development workers claim that the RHDS-sponsored “community pharmacy” has failed. Particular individuals gradually took control of the pharmacy for their personal profit and assimilated it into the circuits of exchange that have carried pharmaceutical products into rural Haiti since the 1940s. The community pharmacy now operates as just another commercial source of medical commodities controlled by local entrepreneurs; it has met neither the
RHDS goals nor the needs of Jeanty residents for a steady supply of essential low-cost drugs. But its failure offers a fine-grained study of the way people's short-term strategies for wealth and prestige redirected the formal plans for health development.

The history of the community pharmacy begins soon after the dispensary was built in 1976 (approximately five years before the RHDS project). A number of wealthy villagers had become active members of the Groupement Communautaire ("Community Group"), a local improvement association begun by the Catholic church. Alarmed by the lack of medications at the newly built dispensary, they formed a "cooperative pharmacy," an organization of about 50 members, each of whom contributed five dollars toward the purchase of medications in bulk in Port-au-Prince. With this initial investment, they created a stock of inexpensive and widely used drugs at the dispensary, which was for a time replenished through sales to patients. Père Joseph also occasionally donated gifts of medications received from France. The cooperative pharmacy thus had several diffuse ties to the Catholic church. It was begun by the Groupement Communautaire, a Church-related organization, and it operated out of the dispensary, built with Catholic funds, and occasionally received donations from the local priest.

The RHDS project soon advanced its own scheme for the distribution of medicines that eventually displaced the cooperative pharmacy. Known as AGAPCO (an acronym for Agence d'Approvisionnement des Pharmacies Communautaires, or Community Pharmacy Supply Agency), this program established "community pharmacies" physically located in (but independent from) village dispensaries. In the AGAPCO plan, each pharmacy would be owned and managed by a committee of local residents. The DSPP furnished them with essential drugs through its own supply system. Each community pharmacy thus received an initial lump sum of RHDS money and purchased drugs according to an approved list from DSPP warehouses. As in the pre-existing "cooperative pharmacy" in Jeanty, the revenues from drug sales were supposed to go toward the purchase of replacement stocks.

The problems with this plan soon became apparent in Jeanty (and in rural villages throughout the country). Money "disappeared," the inventory was not renewed, profits were squandered, the prices paid by villagers gradually rose, and pharmacy managers had only a meager clinical understanding of the medications they sold. In response, health planners attempted to fine-tune the AGAPCO plan, as reported in numerous project documents (Bates 1985; Bisaillon 1988; Rohde 1986). In Jeanty, people were dissatisfied from the very start, and they saw no improvement in the pharmacy over the years. In their eyes, the state had simply taken over a thriving local institution and absconded with the profits meant for the community.

A group of young men in Jeanty described this takeover in blunt terms: "The state seized it. It was as if you had a business in your house, the state came in and substituted its own business for the one you had." Their attitude, shared by many other residents, fits squarely with peasants' long-standing suspicion of the Haitian state. This was the typical result of state intervention in local affairs: "That's why it doesn't have any medications now. It is up to the state to send medications, and they can just as well send some one year and then forget about it for two. Back then
[before 1984] there were many more medications than now. Nowadays, the dispensary is just good for weighing babies, giving shots, things like that."

The bitter response of Jeanty residents belies the rhetoric of project documents, which glowingly describe the AGAPCO program as the extension of urban-based medical services into underserved regions. However, the angry local critique does not fully explain the scarcity of medications and the high prices paid by patients. The meager achievements of the AGAPCO pharmacy in Jeanty reflect not so much theft by the state but rather the efforts of a handful of people to transform the community pharmacy into a private business actually outside of the state’s control.

Villagers receive prescriptions as part of most dispensary consultations, and they usually fill them on the spot at the community pharmacy. The pharmacy director, Michelle Rosier, orders the drugs, sets their price, sells them to patients, and maintains sole control over the use of profits. Both she and the AGAPCO committee are widely suspected of skimming off the profits generated by the sale of drugs. Consequently, the fund is now in deficit, and there are far fewer medicines. In light of the many problems with the “community pharmacy” reported from other Haitian communities (see Bisaillon 1988), the villagers’ suspicion is well-founded.

Both the local dispensary staff and international health planners trace this corruption to problems with the RHDS project itself. Thus the resident nurse faults the AGAPCO-imposed “pharmacy committee,” which has no history of supporting either the dispensary or the original cooperative pharmacy. In an unpublished evaluation, an international consultant agrees with this assessment. Bisaillon (1988:5) lists several reasons for the failure of community pharmacies, including poor training of personnel about medications and embezzlement of funds due to inadequate DSPP supervision. Although their explanations arise from opposite poles of the international health enterprise—a rural villager and a highly paid international consultant—they both measure the failure of AGAPCO by the distance between its stated goals and its operation on the ground; the main problem is the gap between planning and performance (cf. Black 1991; Justice 1986).

However, most residents of Jeanty who actually use the dispensary know nothing of its stated goals. For them, the current operation of the “community pharmacy” represents neither personal corruption nor the perversion of well-intentioned comprehensive PHC planning. Viewed from their practical standpoint, the AGAPCO pharmacy has been recreated as simply one of the many commercial sites where biomedicines are bought and sold in Jeanty. Customers interact with Michelle just as they do with the itinerant pill sellers, market women, and local shopkeepers who also sell proprietary medications. Moreover, Michelle Rosier operates it as a more profitable version of the other long-standing channels for the sale of pharmaceutical commodities.

The AGAPCO pharmacy does not differ in kind, for example, from the itinerant pill-sellers who hawk their wares with large glass jars full of colorful antibiotics slung over the shoulder, or the market women who sell such medicines along with small packaged foods, cigarettes, and matches in the marketplace. As it currently operates, the AGAPCO dispensary pharmacy resembles a more sophisticated and profitable version of these other village enterprises, not the product (or corruption) of formal development plans.
In each case, the medications originate from outside Jeanty, and the community pharmacy thus relies on the same distribution system (from point of manufacture to point of sale in Jeanty) as the pill-sellers and market-women. The community pharmacy simply benefits from a certain economy of scale because the DSPP manages the original procurement and transport of medicines to Jeanty.

Moreover, for buyers and sellers in all settings, medicines are commodities: secular and disenchanted objects that dissolve long-standing local social ties and create exchange relationships based on anomic self-interest (see Brodwin 1992). The vendors (Michelle Rosier or the market drug hawker) rarely know more than their customers about the medical effects of their product. The transaction over medicines in each of these settings is anonymous; the actual purchase is accomplished quickly and with little conversation, and it ends with the individual paying for the product on the spot and then leaving to ingest or apply it elsewhere. This anonymity is a hallmark feature of the commoditization of pharmaceutical substances (cf. Whyte and van der Geest 1988).

The differences that do exist between the community pharmacy and the other vendors of biomedicines primarily make the pharmacy more profitable, rather than separate it categorically from these other settings. For example, Michelle has a guaranteed market. Because of its location within the dispensary and its origin as a component of the RHDS program, the community pharmacy fills many of the prescriptions written by the clinical staff. Michelle need only wait in the dispensary (or at home) and customers will come to her, whereas other vendors must advertise and search out customers in the crowded market. Compared to other points of sale for biomedicines, the community pharmacy simply has greater capital, an advantageous location, and a director who knows the medications most often prescribed by the dispensary staff.

Conclusion: The Underdevelopment of Health

On the one hand, the RHDS project in Jeanty has mitigated the maldistribution of medical resources typical of rural Haiti, especially through the well-attended maternal and child health clinics, which bring basic preventive care within the reach of local residents. On the other hand, the AGAPCO program subverted a well-functioning pharmacy with deep ties to the local Catholic church, and this means that far fewer drugs are available at prices that clients could afford.

However, these successes and failures cannot be explained by the usual frameworks for the anthropological analysis of PHC projects. The high attendance at maternal and child clinics was not achieved by casting health-promotion messages in locally appropriate idioms. The failure of the AGAPCO is not reducible to the hegemony of capitalist medicine (although the project was funded mostly by USAID) or a simple gap between planning and performance. Neither the neo-Marxist nor liberal paradigms for the study of international health development capture the way that specific individuals resisted, circumvented, or appropriated the material and symbolic resources that the RHDS project directed into Jeanty. Jeanty residents have localized dispensary life according to the code of formal deference governing other settings where they petition representatives of national institutions, who are themselves seeking to extend their power and legitimacy. As the pharmacy came under the control of several entrepreneurial local residents, it lost many of its
distinguishing features as a creation of national (and international) planning agencies. It now resembles yet another vendor in the informal commercial market for biomedicines in rural Haiti.

People’s responses to the RHDS project resembled a form of “structured improvisation” (Bourdieu 1990). The way they engaged with clinic services and the pharmacy was structured by cultural orientations with a deep history in rural Haiti. Their deference to supralocal authority and their entrepreneurial zeal in the face of new opportunities have been ratified as effective and sensible ways to act for many years. By following these strategies, people transformed the shape of imported PHC services, and their action makes the final form of PHC in Jeanty appear as an improvised, and rather distant, approximation of the planners’ original intentions. The social framework of the RHDS project thus emerged from the practical logic that local residents applied to new forms of material and symbolic power.

This approach offers a new way to interpret “community participation” and its effect on the success of PHC projects. The term participation is a vague and flexible notion that fosters the illusion of consensus among factions with radically opposed interests (Morgan 1993). In PHC activities elsewhere in Latin America, the state uses it in a technocratic sense, which has the ultimately repressive aim of denying rural communities the power of self-determination and maintaining the current political structure (Morgan 1993:13, 162). The situation in Haiti is somewhat different because of the particular forms of self-aggrandizement practiced by the Haitian ruling class for most of this century (see Nicholls 1984; Trouillot 1990).

The Department of Health originally cooperated with the RHDS project and its rhetorical commitment to rural PHC, but then neglected its implementation in rural communities such as Jeanty. Unlike elsewhere in Latin America, the state in Haiti has not taken control of this rural health program in order to increase its domination of marginal groups or ward off potential threats to its legitimacy (Morgan 1989). Indeed, the state proceeded in just the opposite direction. Consistent with the centralization of power in Port-au-Prince, the state established routine forms of bureaucratic control in Jeanty but then essentially withdrew from the field and left the ultimate shape of RHDS programs to the play of informal long-standing local interests. The fate of this PHC project in Haiti was not determined by the contest between popular pressuring tactics and the state’s ability to control them (Morgan 1993:164). The relevant contests in Jeanty concerned much more local matters: the different available forms of village-based prestige and power.

The history of the AGAPCO program in Jeanty shows that the underdevelopment of health is also a local affair, and not just the dubious achievement of outsiders. Health planners’ misapprehension of local health beliefs and politicians’ desires for greater control do not alone account for failures of the community pharmacy. We must consider not only the intentions of public health planners and state bureaucrats, but also the counter-intentions (or unrelated intentions) of local villagers (cf. Ferguson 1990). These counter-intentions are elements in people’s long- and short-term strategies to appropriate symbolic and material resources. This analysis thus moves away from the utilitarian and cognitive frameworks used by many anthropologists to study people’s use of medical services in developing countries (e.g., Sargent 1989; Young and Garro 1981). The basic questions in the
case of Jeanty concern the place of new medical services in people’s routes toward social mobility and cultural prestige, not the relationship between medical beliefs, socioeconomic factors, and treatment choice. The goal is to illuminate the stakes raised by people’s responses to PHC initiatives and the ultimate effect of their responses on larger cultural processes, not the decision-making calculus that individual care-seekers may follow.

In the long run, the ways that people appropriate the symbolic and material resources introduced by the RHDS project may well reproduce dominant social relations. They may deepen local inequities (between wealthy and poor village families) and strengthen the power and persuasiveness of state-sponsored institutions that extend into peripheral communities (exemplified by the deference shown in the clinic, in the tribunal, and in the schools). Ultimately, the RHDS project may “serve power,” but it does so in a different way than the powerful could have imagined (Ferguson 1990). Anthropologists of international health projects should pay attention to the local practices that produce this outcome.

Notes

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1. I carried out a total of 17 months of fieldwork in Jeanty: one year of continuous residence in 1987–88 and return visits in 1990 and 1992. Because the political situation in Haiti remains volatile, the names of this town and its inhabitants have been changed.

2. Primary health care refers simultaneously to a utopian ideal, a call to political action, a guideline for development policies in the world’s poorer countries, and a vast set of specific medical and public health interventions. As an ideal, PHC envisions essential medical services that are low cost, universally accessible, and “culturally appropriate,” that is, calibrated to local health beliefs and social roles (Mull 1990). As a message of political mobilization, it urges fundamental social changes, in particular, redistributive programs and the subversion of oppressive hierarchies, in order to achieve genuine improvements in health (see Heggenhougen 1984). But as a set of development policies and medical interventions, PHC advocates by necessity depend on governments and global systems of power that they simultaneously hold responsible for people’s poor health status. The multiple meanings of PHC are thus contradictory, and the contradictions underlie the basic conflicts in the anthropological analysis of PHC programs.

3. The failure of PHC in Guatemala exemplifies the views of culture and agency in the political economy approach (Heggenhougen 1984). Village health promoters were trained to provide comprehensive PHC service, including installing potable water systems, purchasing land co-operatives, and leading other agricultural improvement projects. Through their work, they contributed to the emergent collective identity and political mobilization in the historically disenfranchised Indian population. Precisely for this reason, the country’s landed elite and military violently repressed the PHC movement and killed many individual health workers. These PHC initiatives obviously did not fail because of cultural miscommunication; they were rather prevented from succeeding by dominant economic and political interests.
4. This practice-based approach focuses on much more than the standard list of health-care practices found in medical anthropology (biomedical or indigenous therapies, help-seeking decisions, efforts at illness prevention, and so on). The term practice refers to a broader category of behavior: those activities and interactions by which people reproduce or transform the basic social arrangements that structure their local worlds (see Ortner 1984). Under this definition, virtually any kind of activity could be considered as practice, but research usually examines the active strategizing and calculating people engage in for short-term gains in material resources, prestige, or other interests. A practice-based approach to PHC thus privileges people’s active appropriation of biomedical services and ideology as well as the effects of their action in the local social field.

5. Because the reorganization of medical services accomplished by the RHDS has not been superseded to this date by another program, I employ the present tense to describe the effects of the RHDS program in Jeanty during the first period of fieldwork (1987–88).

6. For example, each woman attending the pediatric clinics is processed through the same routine: retrieving her child’s growth chart/immunization record, writing the required immunization on the mother’s appointment card, weighing and immunizing the child, and entering the new injections on the chart.

7. In saying the people “assimilated” social life in the clinic to familiar models of behavior, I am drawing from and extending Jean Piaget’s original notion of assimilation as a basic process of psychological development. In Piaget’s account, assimilation refers to the active incorporation of a new perceptual object into previously stabilized patterns of recognition and behavior (Piaget 1976:7–8). The individual thereby preserves unchanged the whole repertoire of actions inherited from his/her life up to that point. A new sensory datum or experience simply takes up a place in the previously acquired psychological structure or set of routinized behaviors. For Piaget, assimilation was one aspect of individual psychological adaption. I am extending this term to refer to a general style of response: something that characterizes a range of behaviors on the part of many different people. Assimilation, in the present context, refers to the process by which people familiarize a new element of the health-care system to pre-existing and locally relevant cultural logics and forms of practice.

8. In a systematic sample of charts for adult patient contacts at the Jeanty dispensary clinic over three years (N = 294 charts), virtually every entry noted at least one drug prescribed by the nurse or physician.

9. During the period of research, the region of Jeanty was untouched by political violence or most other forms of state-sponsored intimidation. After the fall of Jean-Claude Duvalier, most political struggles unfolded in Port-au-Prince and few other provincial capitals. After the coup d’état toppling Jean-Bertrand Aristide, the legitimate president of Haiti, in September 1991, the de facto government embarked on campaigns of terror that reached deep into the countryside. This political repression decreased with the restoration of Aristide’s government by the American military occupation beginning in September 1994.

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