

Globalization, Cultural Reasoning, and the Institutionalization of Social Inequality

Racializing Death in a Cholera Epidemic<sup>1</sup>

essay presented for discussion at a conference on  
Place, Locality and Globalization  
Saturday, October 28  
University of California, Santa Cruz

Charles L. Briggs  
University of California, San Diego

In Love in Times of Cholera, Gabriel García Márquez (1985) creates a powerful image of Latin American modernity in the character of Dr. Juvenal Urbino. Urbino is called back from France, where he has studied medicine and embraced European modernity, in order to save the coastal Colombian city in which he was born from that quintessence of the premodern world of ignorance, filth, and backwardness—cholera. García Márquez captures exquisitely the terror that is conjured up by the disease—thousands of bodies wracked by rivers of diarrhea and vomit, cramps, sunken eyes, blue lips, and twisted limbs, many of them dying rapidly. But Urbino is armed with that quintessence of modernity—hygiene. The terror inspired by the epidemic enables Urbino to transform both the urban landscape and bodily practices in keeping with the dictates of Continental biopower, neatly mediated by his own patrician class standing.

Narrativizing cholera terror thus provides a land of tropical romance and decadence with an opening for entering modernity—insofar as its residents accept bodily and social surveillance and regulation. García Márquez's readers will recall, however, that the triumph over cholera is not absolute or irrevocable. After Urbino's death, his widow is united with the man who has loved her since his youth. In the final scene, the aged lovers find a zone that is cut off from time and space as they travel along a river in a boat whose cholera quarantine flag precludes landing in any port, creating a liminal space in which they can culminate a love long repressed.

This scene is remarkably prescient. At the time that Love in Times of Cholera was published, the disease had been absent from Latin America for nearly a century. A cholera outbreak began in Peru in January of 1991, however, and Peruvian public health officials had reported 322,562 cases and 2,909 deaths by the end of the year (PAHO

1992:5). By the following year, all countries in Latin America but two had reported cholera outbreaks. The devastating effects of this epidemic and the powerful social, political-economic, and moral questions it raises were painfully apparent eastern Venezuela, where some 500 people died from cholera in the Orinoco Delta in 1992-93. While cholera can kill an adult through dehydration in as little as 10 hours, it is easily treated by rehydration and antibiotic therapies. The number of deaths resulted not only from gross inadequacies in available medical services but also from the failure of public health institutions to inform residents that cholera was likely to arrive and that patients must seek treatment immediately. In some small communities, as many as a third of the adults died in a single night. The epidemic thus compounded insecurity around issues of life and death in a region in which more than half of the children die before reaching puberty and approximately 60 percent of the population has tuberculosis.

The national publicity that focused on the epidemic threatened the legitimacy of public health institutions in Delta Amacuro state and the regional government's hold on power. The stigma attached to the emergence of a disease associated with backwardness, lack of hygiene, and poverty challenged the right of these institutions to claim the mantle of modernity, the very illusion that they were bringing medicine, sanitation, and health to the region. Thus, while the depictions of cholera that I analyze here obtain much of their meaning and force from the way that they engage modernity, they do in quite a different way than the stories of crafted by García Márquez and by historians of nineteenth-century cholera epidemics in the United States and Europe (see Rosenberg 1962 and Delaporte 1986, for example). Indeed, the contemporary narratives talk less about the promise of modernity than of the failure of modernity, or, alternatively, the way that such promises are performed during the era of rapid globalization. Cholera narratives had to grapple with the collapse of modern epistemologies and practices and concerted attempts by institutions to avoid getting pinned with the blame.

I argue here that the multiplicity of narratives that purported to describe the epidemic and account for why it took place constituted social forces with as much power to shape health conditions and the social and political-economic relations as the Vibrio cholerae itself. These accounts provided important means of deepening, extending,

naturalizing, and challenging the forms of social inequality that had been constructed and sustained by modernity and in particular how they have been deepened and reimagined through an active process of globalization. In the face of a national scandal caused by the epidemic, public health authorities and other officials racialized the disease, thereby reimagining and extending racial boundaries; in doing so, they attempted to transform a moral and political crisis into a means of consolidating the power of their institutions as well as legitimating and naturalizing the acute social inequality that was emerging throughout Venezuela in the wake of globalization and neoliberal policies. I also explore the way that national public health officials constructed the epidemic and how international epidemiologists in leading public organizations explained the sudden onset and dispersal of cholera in Latin America as a whole. Here, too, discourses of culture play a key role in the way that social inequality gets connected with cholera. This article asks why a broad range of institutions are incorporating cultural reasoning as part of their ideologies and day-to-day practices precisely as globalization augments social inequality and presents new challenges to the legitimacy of institutions and nation-states. The depth of the racialization process that shaped representations of the cholera epidemic can provide us with deep insights into why the fit between cultural reasoning, institutions, and globalization is so tight.

#### CULTURAL REASONING AND THE GLOBAL INSTITUTIONIALIZATION OF RACIAL INEQUALITY

A number of writers suggest that cultural reasoning is becoming deeply inscribed in the discourses used by institutions of the nation-state in shaping and legitimating relations of social inequality. Critics have suggested for several decades now that anthropologists use cultural analysis in exoticizing subalterns in such a way as to naturalize colonialism, internal and external.<sup>2</sup> Kristin Koptiuch (1991:94) suggests that anthropology and folklore play a role in “third-worlding” residents of US inner cities, thereby rendering resistance “potentially liable to domestication, displacement, reeducation, incarceration.” But cultural reasoning now reaches deeply into institutions that less commonly employ social scientists. Jack Campisi (1991) and James Clifford

(1988) have argued that US courts use the language of culture in order to deny identities—as Native Americans—to persons claiming land rights. Jacqueline Bhabha (1996) suggests that the Immigration and Naturalization Service uses cultural arguments in constructing a double standard; while human rights discourses may be used in condemning gender-based discrimination and female genital mutilation as barbaric, denials of refugee protection to individuals seeking to escape them are justified through a language of cultural relativism as a need to be sensitive to the norms of the home country.<sup>3</sup> Nilda Rimonte (1991) suggests that assertions regarding Asian “cultures” have shaped the way that Asian immigrants and Asian-American have been treated in US courts—at the same time that she herself uses generalizations regarding “traditional” Asian cultures. The texts that provide recipes for racial profiling and racialized compilations of “mug shots” often add “cultural” characteristics to the physical features used in surveillance tactics aimed at Asian Americans.<sup>4</sup> Images of “traditional culture” similarly shape the way that the US media portrays legal institutions in other countries and the social relations they regulate, as Susan Hirsh (1995) suggests. Paul Farmer (1992, 1999) argues that epidemiologists and public health officials conflate structural violence against poor populations with cultural difference.

Etienne Balibar (1991) suggests that cultural logics deployed by anthropologists are inextricably linked to the history of racism in the twentieth century. He suggests that “anthropological culturalism” constituted a major threat to the legitimacy of biological reasoning. Nonetheless, racists deftly appropriated cultural reasoning as a new means of legitimizing racism, construing social groups as separated not by biological but by cultural differences. Following anthropological frameworks, social groups are characterized as having equally coherent and systematic cultures that pattern both thought and behavior; nevertheless, their differing tenets orient their bearers toward distinct goals and provide them with contrastive modes of reasoning and acting. Relatively homogeneous cultural patterns that lie in the heads of those who “bear” them are thus granted causal status in producing social inequality. As Balibar (1991:21-22) notes, cultural differences are alleged to be “insurmountable” and to naturally lead to racism and social conflict.

Since Balibar invites us to think of culturalism as a dominant logic of late capitalism, we might be led to believe that cultural reasoning would lose its potency in the wake of postmodernism and globalization. I want to suggest a number of reasons as to why culturalist reasoning needs to be repositioned historically, socially, and politically economically before we project its possible demise. Bauman and Briggs (1999) suggest that representations of customs and worldviews played a crucial role in shaping the forms of social inequality that constituted modernity as early as the seventeenth century, long before modern evolutionary or other forms of biological reasoning gained ascendancy. Similarly, biological and culturalist logics are hardly mutually exclusive in racist discourses; Packard's (1989) demonstration that health-based arguments for Apartheid policies in South Africa moved from a more cultural to a decidedly biological mode of reasoning suggests that comfortable linear narratives that project the displacement of biological by cultural reasoning are dangerously misleading. But two gaps in Balibar's account strike me as of particular importance in grasping the role of cultural reasoning in the wider social and political implications of the epidemic.

First, Balibar seems to suggest that cultural reasoning stands on its own as an autonomous rhetoric; I argue here that projecting the illusion of consistency and autonomy provides a means of drawing attention away from how formulations placed within this cultural frame intersect powerfully with other discourses. These juxtapositions extend the liberal appearance of culturalist reasoning to arguments based on universalistic discourses of nature, sentiment, rights, and so forth; they also legitimate the right of the nation-state to police difference. constructions of motherhood provide especially rich arenas for juxtaposing contrastive discourses.

Second, Balibar's account locates cultural logics too much at an ideological level. As such, they seem to be too free floating, too homogenous and monolithic. The key here seems to be one of grasping how cultural legitimations of social inequality gain constitutive force within the day-to-day practices of institutions. Before we posit broad generalities for nation-states or for contemporary racism in general, it would be useful to examine what particular features of the institutional sites in which cultural logics are used and the how broad historical, cultural, and political-economic parameters of the

historical juncture in which they are operating are connected to and benefit from specific features of cultural reasoning. In doing so, we can map how cultural reasoning comes to serve as a basis for racialization, “the extension of racial meaning to a previously racially unclassified relationship, social practice or group” (Omi and Winant 1986:64). Exploring this social cartography not only points to the way that globalization is reshaping institutions and ideologies but provides a sharper focus as to the nature of globalization itself.

### CHOLERA IN DELTA AMACURO, VENEZUELA

In the Orinoco Delta, a fluvial region with an estuarial coastline that consists of about 40,000 sq. km. and a population of about 40,000 (OCEI 1992), medical services are limited and transportation is difficult. The region has among the highest rates of malnutrition and infant mortality in the country. A study conducted in the 1950s-1970s by Miguel Layrisse, Johannes Wilbert, and their colleagues placed prepubescent mortality at 50 percent (Wilbert 1980). Research in the northwestern delta in the late 1990s suggests that 36 percent of children die in the first year of life (SOCSAL [1998]:12). Tuberculosis is so common that the majority of adults in some areas are symptomatic, and many die from the disease.<sup>5</sup>

The cholera epidemic continued to exert detrimental effects on living conditions after new cases had slowed to a trickle by the middle of 1993. As insecurity surrounding everyday health conditions was transformed into terror by the outbreak, thousands of delta residents fled to the mainland, and groups began living as mendicants on the streets of the capital, Caracas, and other major cities. When this exodus drew the attention of the press, the national government and officials in other states reacted by rounding up the refugees and sending them back in military transport to the delta; the cycle is still repeated frequently. The constitutional rights of persons who looked “indigenous” were violated for a time by confining them to the delta region. Both the cholera epidemic and the exodus of refugees prompted criticism of the Delta Amacuro State government by national officials, other state governments, and opposition politicians. Deeming “the Warao” to be a political liability, politicians and administrators subsequently turned an

even deafer ear to conditions in the delta, responding to petitions for improvements in medical services, political representation, human rights, land expropriation, and environmental degradation with a mixture of disinterest and contempt.

The national publicity that focused on the epidemic threatened the legitimacy of public health institutions in Delta Amacuro State, and some accounts characterized the epidemic as evidence of major shortcomings on the part of the state government as a whole in terms of its “indigenous policy.” The stigma attached to the emergence of a disease that conjures up visions of backwardness, lack of hygiene, poverty, inadequacy of health infrastructures, and negligence on the part of public health and other authorities led to the dismissal of the directors of the Ministry of Health and Public Assistance, the Office of Indigenous Affairs, and other agencies. It also seems to have contributed to the replacement by voters of the Democratic Action party with the Movement toward Socialism in the state government in 1993.

Government institutions responded in two primary ways. First, an unprecedented avalanche of resources was mustered to control the epidemic. Additional physicians were sent to rural clinics, and temporary treatment centers were established in areas where the greatest concentrations of cases were emerging. These efforts are clearly to be commended. Second, officials produced and circulated accounts of the epidemic that deflected the blame away from government institutions and onto the cholera victims themselves. The most pervasive feature of these representations was the racialization of cholera in the region. The social and political power of the opposition between “the Warao” and “the criollos” or indígenas (“indigenous people”) versus “the national society” was mobilized to the task of depicting the epidemic as an “indigenous problem,” thereby rendering cholera, the space of the delta, and the Warao population synonymous.<sup>6</sup> Conversely, cholera cases among criollos in Tucupita (the capital of Delta Amacuro state) and in the delta were virtually erased in public commentary on the epidemic.

Dr. Clara Mantini-Briggs, a Venezuelan public health physician, and I visited every area of the delta, and we conducted interviews in most of the larger communities and a multitude of smaller settlements. These materials include a host of narratives that

relate conditions prior to the epidemic, how cholera arrived and who it struck, efforts to save patients, and beliefs regarding the nature of the disease and why it had such devastating effects. The recordings made in the delta were supplemented by extensive interviews in Tucupita and surrounding cities with physicians, nurses, and other medical workers who treated cholera patients as well as politicians, missionaries, merchants, transportation workers, journalists (newspaper and radio), and others. We also conducted interviews in Caracas with officials in the national offices of the Ministry of Health, members of congress, and other government officials. Visits to New York (UNICEF), Atlanta (Centers for Disease Control), Washington (Pan American Health Organization), Geneva (World Health Organization), and Bangladesh (ICDDR,B) provided first-hand information regarding how cholera research is conducted and how both clinical and policy-oriented formulations are generated on an international level.

With regard to attempts by public health officials to account for the epidemic in Delta Amacuro, the concept of “cultural idiosyncrasy” provided a rhetorical foundation on which to build explanations of why cholera affected indígenas in the delta and not criollos. “Warao culture” was characterized as a set of costumbres (“customs”) or a “millenarian cultural pattern”; food preferences and modes of preparation and consumption were cited as key elements of the “customs” that rendered delta residents highly susceptible to cholera. When he visited the region at the beginning of the outbreak, the Minister of Health, the highest-ranking public health official in Venezuela, announced that the high rates of cholera infection were due to “eating habits” in the delta (Notidiario, 1992a). Some two weeks into the epidemic, an article based on statements by public health officials that appeared in the local paper provided a totalizing image of the deep embeddedness of the consumption of crabs in indígena culture. The article narrates a journey undertaken by “various Warao families” to capture crabs, followed by their consumption in “the annual celebration of the magical liturgical festival know as ‘nowara’ in which they celebrate a collective banquet with crabs and yuruma, starch that is extracted from the moriche palm. Unfortunately, the crabs had been infected with the vibrio cholerae” (Notidiario, 1992b). Such accounts draw their plausibility from the widespread assumption, reported in the Venezuelan press, that the cholera was spread in

Peru by the consumption of ceviche (see Cueto 1997) as well as from ethnographic studies by anthropologists and missionaries of “Warao culture.” Detailed in situ investigations are not needed or undertaken; for example, the nowara is not celebrated in the northwest delta.

The regional epidemiologist went on to create a totalizing image of the domestic space occupied by indígenas: “They eat on the floor, and they defecate—or let’s say, they don’t have a system of defecating discretely. They do it in the open air. The flies, which land on food, land first on the feces and then on the food and then on the bottle, the pacifier of the child, and then they give it the bottle” (Interviewed 14 January 1994). Going far beyond scientific descriptions of possible routes of transmission of cholera, such statements evoke stereotypes of indígenas as ignorant, unsanitary, and backward.

These “millenarian cultural patterns” were deemed to be too deeply ingrained ever to be changed. By locating the causes of high morbidity and mortality in the minds of the patients and their communities, these officials erased the possibility that political-economic and institutional structures that limit access to adequate schooling, potable water and sewage facilities, health education, and medical treatment might have played a role in creating conditions that are highly hospitable to cholera. In attempting to identify the cultural core complex that prompted such high morbidity and mortality, the director of the Regional Health Office characterized the way that indígenas (and Warao mothers in particular) view issues of health, life, and death:

The Indians—they're people who accept death as a normal, natural event in their lives. And when an Indian dies, it's not anything transcendental: an Indian dies and nothing happens. There isn't, there isn't this fondness for life, this affection for life among them. “It's all the same: a child dies and I have another tomorrow and it dies.” Okay, maybe it's because it's always been like that—they have their children and they die. So then this—well, they will think that when a disease comes along that decimates them, it's because one of those evil spirits is getting even with them. . . . In their case, we have to teach them to take care of their lives, because they don't love their lives. [Interviewed by CLB, 31 March 1995]

In this statement, the highest public health official in the Delta Amacuro state at the time of the epidemic argued that the absence of an “affection for life” among Warao mothers constituted an almost insurmountable obstacle to the delivery of health care, and particularly to programs of health education. She pins responsibility for the high mortality, both during the cholera epidemic and in general, specifically on Warao mothers. This image of mothers who do not mourn certainly does not match my experience watching women in the delta compose and perform powerful and poetic laments following the death of family members, including infants (see Briggs 1992, 1993).

The woman who is callous to the death of her own children is not only a widely dispersed image but seems to be deployed frequently and with especially powerful effects in areas in which infant and child mortality are high. Visions of poor, incompetent mothers juxtapose dimensions of gender and class in generating the sense that the objects of these representations exhibit unnatural emotional and behavioral dispositions. Nancy Scheper-Hughes (1992) suggests that supposedly universal norms of motherhood reflect the political-economic position of white, middle-class women; poor mothers thus seem to be defective or unnatural deviations from these norms. Marilyn Nations and Linda-Anne Rebhun (1988) argue that the image of the mother who is indifferent to the illness and death of her own children has been widely used as a political tool for covering up the structural factors that lead to high infant mortality in Brazil. These constructions of poor women in South America echo a Euro-American pattern that depicts the sexuality of women of color quite differently from that of white women (see Crenshaw, 1989; Wyatt, 1982). In the Delta Amacuro, race joins gender and social class in creating these powerful images. The allusion is less direct in this passage, but the director is also drawing on a common stereotype of *indígena* women as lacking respect for and control over their own sexuality, wantonly (and perhaps promiscuously) having babies one after another. Women who appear to fail so miserably at such a “natural” task as loving their children, nurturing them, and mourning their loss, seem less than fully human. The fall from complete humanity can easily be extended to the “group” or “race” as a whole, thereby legitimating racist practices.

Women who are classified as indígena are subject to multiple forms of subordination, in Kimberle Crenshaw's (1989, 1991) terms, which makes them particularly vulnerable to acts of violence and simultaneously deprives them of access to most forms of legal protection. The step from moral and medical to legal culpability follows easily. In the opening days of the cholera epidemic, a young indígena woman who was working as a domestic for a criollo family in Tucupita was convicted of homicide in the death of her newborn. Flagrant acts of labor exploitation, medical malpractice, and police violence—as well as the common understanding that she had been raped by her employer—only figured as evidence in the case against her and never became the subject of legal proceedings in their own right. This highly visible criminal case was read by many persons who consider themselves to be criollos as proving that indígena mothers are incapable of learning how to protect their families from cholera or other diseases and are so callous as to be capable of slaying them (Briggs 1997; Briggs and Mantini Briggs 2000).

The cultural logic invoked by public health officials increased the stigma attached to being classified as Warao. The way that public health officials and politicians attempted to “explain” the cholera epidemic bears a double relationship to social inequality. At the same time that official responses reflected race-based patterns of stratification, statements and actions also augmented the depth, sense of concreteness, and social power of racial formulations by constructing the epidemic as a categorical and transparent confirmation of the intractability of “Warao culture” to modern hygienic norms and an unbending resistance to extensive involvement with medical practitioners. Cultural reasoning provided a language for recasting these assertions in a pseudo-scientific language of cultural difference, a distinctly modern rhetoric that seems to replace the politically suspect character of bald racism with a liberal tone. Angered by the collapse of tourism in the region and the strident criticisms that were sparked by the epidemic, politicians and government officials grew even less willing to invest in programs that would improve economic and other conditions in the delta. The overall result was thus an increase in malnutrition, an erosion of resources available to rural

clinics, and a decrease in the availability of the motorized transport that is needed to get patients to the clinic in time.

#### CHOLERA, GLOBAL CAPITAL, AND GENOCIDE: NARRATIVES OF RESISTANCE

The circulation of narratives that sought to account for the cholera epidemic was hardly confined to the ranks of institutional officials or even to persons who consider themselves criollos—the official narratives made their way into delta communities as well. Reports regarding the epidemic, interviews, panel discussions, and public service announcements, were broadcast on Radio Tucupita, which reaches most areas of the delta. Schoolteachers and others brought copies of Notidiario from Tucupita into the delta, and these individuals often related the newspaper stories to persons who could not read or who were less fluent in Spanish. Physicians and other persons working in conjunction with the Regional Health Office not only discussed cholera etiology with patients and their relatives in rural clinics but also visited an extensive range of communities and gave talks on the disease. Cholera patients and their relatives often incorporated these accounts into their own narratives. While some delta residents, particularly schoolteachers, nurses, and other professionals, accepted the tenets of these rhetorics, most of the accounts that we recorded in the delta contested the claim that “Warao customs” were responsible for the high rates of morbidity and mortality.

Several persons who speak the language referred to as “Warao” fluently, but who do not consider themselves to be of “Warao descent,” work as activists in defending indígenas against governmental institutions and businesses that operate in the delta. Several activists proposed narratives that drew on aspects of public health discourse in accusing these authorities, other governmental agencies, and business interests of starting the epidemic. One individual, whom I will call the Forestry Activist, has challenged commercial extraction of hardwoods and palm hearts in the region. Government officials accused him of convincing “the Warao” to stage protests in Tucupita, Barrancas, and even as far away as Caracas. The Forestry Activist offered this account of the epidemic: “It isn’t the case that cholera just sprung up (no fue que nació)—cholera was planted here by boats that bring goods to the basic industries and that were quarantined at anchor just

off the coast, which was not an appropriate place.” This account juxtaposed a scientifically based view of the etiology of cholera—that the disease is transmitted by bacteria carried by the feces of infected patients—with the assertion that public health authorities deliberately quarantined vessels carrying cholera patients at locations on the coastline, knowing that the tide would draw fecally contaminated water up the tributaries of the Orinoco. Accepting the assertion of public health authorities that the consumption of contaminated crabs and catfish was a primary source of infection, the forestry activist accused these institutions of genocide. Another prominent criollo activist who is also often accused of “stirring up the Warao” suggested that the government had developed a “superbacteria” which it then spread throughout the delta. These individuals seek to authorize their accounts by framing them as eyewitness reports and by incorporating scientific theories of cholera etiology and transmission. Another proponent of the superbacteria theory, who described himself as a biologist, claimed to have obtained samples of this pathogen from delta water. He told us that he had been arrested and his samples were confiscated when he presented this evidence to the director of the Regional Health Office.

Other accounts that circulated in fluvial communities clothed narratives of genocide in the language of supernatural dreams and invading spirits—crucial means of authorizing accounts associated with sorcery and curing (see Wilbert 1972, 1993). Healers confessed that initially they had been stumped by the disease; they couldn't explain or cure it. A number of their colleagues contracted cholera, probably through their efforts to treat patients, and died. Early discussions of the provenience of the epidemic generally yielded bafflement, fear, and impotence: “We don't know what that disease is.”

Within a year of the time that the epidemic began, however, a number of curers began to have dreams that revealed to them the nature of the illness and its provenience, making it possible for them to imbue their explanations with authority. In November, 1992, one of the most renowned healers in the delta was able to draw only on what he considered to be hearsay evidence to suggest what might have caused the epidemic. When I spoke with him the following June, the healer provided this account:

[The spirits] came to attack from over there [points to southwest]. (Briggs: Damn! What a catastrophe!) The Orinoco River here, they came to attack through the Orinoco, that's what they said, from way over there. (Briggs: Way over there.) This very tree gave fruit, this very kind of fruit, fruit, fruit, (Briggs: fruit,) this fruit fell into the waters of the Orinoco, it came swiftly with [the river] over there, in my dream. (Briggs: Aaah! In your dream!) In my dream, they came to attack from over there, they came to attack from Caroní!

From the point of view of vernacular curers, this dream narrative reported crucial diagnostic information on the source of the pathogen, a means of divining its name, and an account of the manner in which it spread through the delta. Many curers asserted that these hebu spirits swarmed into the delta from the mainland “to kill all the Warao.” In dream dialogues, the spirits revealed that they were sent by criollos in order to exterminate “us Warao,” thereby enabling the criollos to take sole possession of the land.

In the wake of privatization and efforts to boost export income, BP Amoco and other corporations have been leased rights to extract oil from sites in the western delta. Although floating colonies of workers, vessels, and helicopters are common on some Orinoco tributaries, residents have been told very little about who these people are and what they are doing. In the Pedernales region, some narratives link the appearance of cholera with the mysterious activities of these transnational corporations, asserting that they have poisoned the water consumed by delta communities. The most far reaching attempt to link the epidemic to global political-economic relations emerged in commentary on the war fought by “Carlos [Briggs'] leaders,” that is, the United States government. Narrators incorporated information on the Persian Gulf War into cholera narratives, resulting in the contention that “Dokomuru's [CLB's] leaders dropped lots of death into the water.” Drawing on accounts of the bombing of Iraq and Kuwait, some narratives assert that that this “death” or “poison” floated through the water from its purported source north of Trinidad and then into the tributaries of the Orinoco, thus infecting delta communities with cholera. The theory of the superbacteria merged with the Gulf War discourse by incorporating both press accounts and popular discussions of

the development of chemical and biological weapons and the perception of criollos as wishing to exterminate indígenas. These narratives wrote me into cholera stories by linking me to the party that had purportedly caused the epidemic, “Dokomuru’s leaders” (the US government).

It would certainly be easy to disqualify this latter set of narratives as being mere conspiracy theories that are based on ludicrous assumptions. These “creative misunderstandings,” as George Lipsitz (1994:162) refers to them, may only miss the mark if we take them with utmost literalness and judge their truth values in terms of particular details of content. However, as Lévi-Strauss (1969[1964]) told us long ago and Propp (1968 [1928]) before him, stories should be interpreted in terms of the frame of reference they themselves establish, not some external concept of scientific or historical validity. The general thrust of the etiological formulations they advance might seem to provide a more productive basis for thinking about cholera than the localized narratives. If the cases in Delta Amacuro formed part of the “Seventh Pandemic,” a truly global phenomenon, and if cholera was absent from the Americas for nearly a century before cases were reported in nearly all of its countries, shouldn’t narratives be pushing our thinking in the direction of transnational connections? If cholera continues to be the disease par excellence of social inequality, wouldn’t it make sense to try to think about how social inequality is being produced and legitimated? Like rumors, conspiracy theories constitute discursive sites that enable persons who lack specialized training and are excluded from insider knowledge to engage in political-economic analysis and explore broad connections in the specific ways that government institutions, corporations, and elites attempt to regulate or suppress.

Note the paradox here. High officials of the Regional Health Service present themselves as the quintessential embodiments of a modernity that is global in scope, given that it draws its authority from scientific research and medical guidelines (such as the Standard Causes of Disease and Standard Causes of Death) that are formulated by international public health organizations. Nevertheless, public health officials’ accounts of the epidemic were primarily localized, focused on what they perceive to be the particular features of the “local” culture and the geography of the delta; their narratives

seldom went beyond the confines of the region or stressed broad connections. The quintessential “locals,” on the other hand, residents of rainforest communities and activists who champion the rights of indígenas, focused their accounts of the epidemic on national and regional political institutions, transnational commerce, and international conflict. I argue below that this apparent switch between “the local” and “the global” has much to tell us about the epistemological underpinnings and political effects of framing dominant representations as modern, scientific, and global.

#### RESPONSES AT THE NATIONAL LEVEL

To be sure, the official narratives that emerged in Delta Amacuro provide a rather extreme example of the way that public health officials and others connect social inequality and infectious diseases. Nevertheless, these two elements were also linked in the perspectives expressed by national public health officials and in articles on cholera in leading newspapers. Statements that were made between January of 1991 and late November of that year, when the first cases were reported in Venezuela, provide a case in point. As a cholera epidemic in Venezuela seemed more and more likely, Minister of Health Pedro Páez Camargo asserted in August of 1991 that “Cholera spreads slowly like an oil stain (mancha de aceite), and there are no methods that enable us to know when it will arrive; but the proximity to Colombia where cholera cases have been detected obliges us to take preventative measures” (Bracamonte 1991:7). A leading Caracas newspaper, El Nacional (1991), spoke of a “national alert” and a “declaration of war on the Colombian-Venezuelan border” even as it described binational cooperation between public health authorities. Cholera was thus enmeshed in a nationalistic rhetoric long before it arrived, becoming a threat not just to the health of individuals but to Venezuelan citizens, institutions, and the nation-state as a whole.

Even as cholera was cloaked in the language of nationalism, particular social groups were singled out as potential bearers of the disease. Before it entered Venezuela, cholera was closely linked to social inequality. In an address to a conference entitled “Cholera is Everyone’s Problem,” Dr. Francisco Aráez paradoxically asserted that “Cholera is an infection that typically and almost exclusively affects very poor people”

(El Mundo 1991). The term Aráez uses, gente miserable, is loaded, as it is also commonly used to designate individuals who are “villainous.” Discussions of poverty and cholera focused on the cerros “hills” (referring to hillside communities) or barrios marginales of Caracas and other urban centers. In this context, “marginal” is imbued with a powerful range of connotations. It conveys a sense of people who stand outside of democratic politics, the formal economy, the law, and morality; accordingly, in the bourgeois imagination, barrios marginales are places in which promiscuity, violence, criminality, and psychopathology are pervasive.<sup>7</sup> The residents of these communities figured prominently in the popular protests in 1989 over President Carlos Andrés Pérez’s attempt to impose neoliberal economic policies. As Coronil and Skurski (1991) suggest, this group continued to be the focus of resistance, of bourgeois anxiety, and of political repression in the early 1990s. The 1989 action is popularly referred to by the bourgeoisie as cuando bajaron los cerros “when they came down from the hills.” Reporter Asdrubal Barrios’ (23 February 1991) reference to way “the daily descent of tons of fecal material from the hills” is converting Caracas into a cholera “time bomb” seems to juxtapose fears associated with popular insurrection and cholera.

Accepting the validity of a poverty-cholera link accorded scientific authority to juxtapositions between demographic discourses of poverty and projections of how many Venezuelans would be infected by cholera and who they would be. Public health authorities, non-government organizations (NGOs), opposition politicians, and journalists all generated their own superimpositions of demographic formulations onto imaginations of cholera. These statistical imaginings, derived from demography, played important roles in creating the very phenomena that they were measuring—the nature, extent, and causes of poverty and social inequality in Venezuela. In addition, they formed key elements of ongoing political debates regarding implementation of neoliberal policies, the repression of popular violence by the police and military, and the very legitimacy of the leading political parties and the nation-state. Nevertheless, these demographic projections were taken as a reliable, scientific window on the social world, as forming a crystal ball that could be used by those who had access to them in reading the choleric future. Even accounts that attacked government actions and institutions thus

collaborated in reifying the power of statistical imaginings for representing the poor majority, foreseeing the future, and planning the nation.

Cholera was also closely linked to indígenas. Zulia State, where cholera was first reported, contains the largest population of persons who are deemed to be indígenas in Venezuela; they are generally referred to as “the Waayú” (also spelled Guayú). Health Minister Páez Camargo brought this population into the national cholera story even before the first cases were reported. When pressed to take action aimed at preventing a cholera epidemic, Páez Camargo stated that “closing the border makes no sense because the Guayú indigenous ethnic group, which is the one that has been affected by the disease [in Colombia], is geographically and culturally a single entity, which feels the same in Colombia as in Venezuela and has no concept of physical border” (Zambrano 1991). This statement was made by a cabinet-level official during an epoch in which the indígenas nation-wide were pressing for recognition of their political, territorial, and human rights. The logic that racializes populations affected by cholera in Zulia and the Delta Amacuro asserts that “they” have no concept of—and thus no concern for—politics. Here public health officials echo the common assertion that it is the indígenas who have excluded themselves from the political sphere—and thus from full, substantive citizenship—rather than being excluded through institutional racism and policies of the nation-state. Senator Lolita Aniyar de Castro went on to link the Waayú and cholera more directly: “With the entrance of cholera in Zulia State, there is a serious risk of an epidemic of considerable proportions among the members of the Waayú indigenous group, since the great majority of those who live in Sinamaica and Paraguaipo don’t have the most elementary sanitary services in the region, in addition to which they drink water from springs (jagueyes), where the animals drink, they don’t have latrines, and their hygienic habits are primitive” (Gómez 1991). She used this powerful image not only in asserting that the Waayú were destined to become the bearers of cholera but why.

Statements by public health officials, politicians, and the press in the course of the epidemic extended a logic that views the poor and indígenas as natural targets of cholera. Rather than going on to detail how these images continued to develop after the first cases were reported in Venezuela in late November of 1991, I want to ask what we are to make

of the ways that cholera and social inequality were linked. It would be easy to condemn Venezuelan public health institutions and their officials by suggesting that they should have invested more energy in discovering how cholera exposed the weak links in their own institutional structures, practices, sanitation infrastructures, and the like rather than in blaming the victims of cholera for their plight. But I will devote most of the remainder of this paper to suggesting two reasons why simply blaming Venezuelan public health officials and politicians is unlikely to be productive in breaking up these sorts of links between infectious diseases and social inequality.

#### CHOLERA AND SOCIAL INEQUALITY IN INTERNATIONAL EPIDEMIOLOGY

The first reason that leads me to deem it inappropriate to blame Venezuela in this regard is that social inequality was a recurrent theme in work by international epidemiologists—including some of the most distinguished cholera researchers in the world. The opening lines of an article on "Cholera in the Nineties" that appeared in the CDC Briefs, an official publication of the Centers for Disease Control in Atlanta, characterized the epidemic in the following terms: "When one thinks of cholera, images of pre-twentieth century sanitation come to mind . . . sewage in the streets, children suffering miserably. Does this sound like a plague from long ago?" Not so. After an absence of nearly a century, epidemic cholera has reappeared in the Americas" (Anderson 1992:1) Here John Anderson, Editor of the CDC Briefs, calls up images of poverty, filth, suffering, and backwardness with which cholera is associated historically—and then connects them to contemporary Latin America.

Since his field is public relations, we might surmise that Anderson enjoys more freedom to incorporate dramatic images into his characterization of the epidemic than specialists in public health. But this process of dislocating contemporary Latin America in cultural, political-economic, and historical terms is also apparent in the way many leading international experts represent the epidemic. Robert Tauxe, chief of the Epidemiology Section of the CDC and one of the world's foremost cholera researchers, provided this description in an article that appeared in Atlanta Medicine and was subsequently reprinted by the CDC: "The explosive spread of cholera in Peru and other

countries occurred in large, poor urban populations. Millions of people in the urban slums of Latin America lack safe piped water and sewage disposal. They live crowded together, in primitive circumstances, eating "fast food" from street vendors and storing their drinking water in whatever buckets can be found" (Tauxe 1992:41-42). Such statements conjure up two sorts of stereotypes about Latin America. First, people in the North often believe that Latin American governments lack the same sense of obligation for providing modern services for their citizens that is felt by the United States, Canada, and countries in Western Europe. Engineer Fred M. Reiff of the Pan American Health Organization suggests that the "rapid dissemination [of cholera in Latin America] is due to many years of neglect in the environmental health sector" (quoted in Marwick 1992:1314). Although infrastructural problems are generally blamed on municipal and national governments, Swerdlow, Mintz, and Rodríguez et al. (1992:29) assert that "illegal connections to major water lines break the integrity of the distribution system", thereby shifting part of the blame to individuals and neighborhoods.

The quote from Tauxe contains another powerful image, that of Latin American poverty. Epidemiologists draw attention to the "health-related behaviors" of communities in which cases were concentrated. Failure to boil drinking water is emphasized, along with such practices as storing water in open-mouthed vessels, washing one's hands in drinking water, and making contact with water while scooping it out of the container (see for example Swerdlow et al. 1992). The failure to wash one's hands with soap prior to handling food or water is often cited. "The food habits of the population" (Tauxe and Blake 1992:1388) are also frequently marked as suspect. A leitmotif is provided by the popularity of such foods as raw or partially cooked fish and shellfish; ceviche, as I noted earlier, became a leitmotif for the Peruvian epidemic. The consumption of food sold by street vendors is similarly scrutinized. A study conducted by researchers from the CDC and Peruvian health professionals published in the prestigious British medical journal The Lancet also blamed attendance at fiestas for increasing the consumption of contaminated food and drink (Swerdlow et al. 1992:31). Such discussions seem to transform popular stereotypes into "factors" that are deemed responsible for the scale of the epidemic and raise them to the level of scientific description.

JAMA published an article by Charles Marwick (1992) entitled "Like Attacker Probing Defenses, Cholera Threatens US Population From Elsewhere in This Hemisphere" that contains a wealth of such images. He juxtaposes depictions of Latin Americans, the global contrast between the premodern South and the modern North, and the lexicon of war and violence in characterizing cholera as a new "threat" to the US population. Tauxe (1992:41) argues that even though water and sewage infrastructures in the US will shield it from the "fury" of the epidemic, the likelihood that more cases will be imported and could even spread suggests that "cholera will no longer be a remote and exotic disease for some Americans and their physicians." CDC reports and other publications thus warned health care professionals in the US to be on the lookout for cholera cases crossing the border from the south. Tauxe and Blake (1992:1390) suggest that "our advanced sewerage and water treatment systems are not available to the entire US population, and cholera could be transmitted in the United States among a homeless, destitute, or migrant farm labor population." Tauxe (1992:42) includes "the immigrants in 'colonias' along the US/Mexican border" as being a potential locus for a cholera outbreak.

Linking infectious disease and social inequality tightly, Tauxe notes that "cholera is a disease of poverty" (1992:42). A problem with this logic is that it tends to erase the particular historical, social, and economic circumstances in which the epidemic is taking place in favor of creating the impression that certain populations are natural targets for "ancient scourges," such as cholera, just as "they have long been known to have high rates of hepatitis, tuberculosis, and typhoid fever" (Tauxe 1992:42). The practices that place populations at risk from cholera seem to emerge from tradition and culture, thereby extracting the epidemic from its historical context.

## OIL, ECONOMIC CHAOS, AND INSTITUTIONAL CRISES

It seems ironic that researchers would downplay the importance of the context in which the epidemic emerged, since the present circumstances in many Latin American countries are striking and strikingly relevant. Once again, Venezuela provides us with an illuminating case in point. An economic crisis that began in the 1980s continues through the present. Venezuela generally directed over 90 percent of its exports to the world

petroleum market; the collapse in oil prices and OPEC restrictions on production thus cut deeply not only into export income but into government revenues as well (Hausmann 1995:1). After Venezuela abandoned fixed exchange rates in 1983, the Bolívar fell from about Bs. 4.5 to the dollar; it currently stands at more than Bs. 600 to the dollar. The drop in oil revenues and the value of the currency turned service payments on \$30 billion worth of foreign debt, largely accrued during the flush 1970s, into a major problem.

At the urging of international lenders, the World Bank, and the International Monetary Fund, newly elected President Carlos Andrés Pérez attempted upon assuming office in 1989 to adopt a number of market oriented reforms aimed at stabilizing the economy, restructuring it through privatization, and enhancing competition. Efforts to balance the budget included substantial cuts in public services. Clearly, the availability of health services was affected by these cuts. Based on government statistics, it has been calculated that the percentage of the population living in poverty increased from 24 percent in 1981 to 59.2 percent in 1990 (Márquez et al. 1993:146, 155). It is now estimated to stand at some 80 percent.

Enter cholera. Even before cases were reported in Venezuela, cholera was deeply woven into the fabric of the crisis. A major concern was economic—politicians were afraid that news of a cholera epidemic would cripple tourism and lead to export sanctions. In Peru, the epidemic has been blamed for the loss of over 147 million US dollars in tourism and even more in agricultural and seafood sectors (Petrera and Montoya 1993). The worry about tourism in Venezuela was quite real, even if the effects were not as massive. Victor Gamboa, president of the government's office of tourism (Corpoturismo) estimated that international tourism dropped more than 40 percent in the first half of 1992 (Escalante 1992); clearly, a February 1992 coup attempt and "popular disturbances" played a role here as well. The impact on the export economy was minimal—few corporations are going to worry that the oil, iron, bauxite, gold, or diamonds they buy will be contaminated by cholera. But an unstated fear seems to have been more important and better grounded. Venezuela's national image, long and successfully cultivated on the international stage, had been roughed up in the wake of international coverage of the political and economic crisis. Then along comes cholera, a

disease that reeks of poverty, dirt, backwardness, and ignorance, a symptom of deep and perhaps irredeemable antimodernity. Venezuela was flung alongside Peru, Ecuador, and Colombia into the recesses of “The Third World.”

The Office of the National Epidemiologist reported 2,842 cases of cholera and 68 deaths in 1992 to the Pan American Health Organization, and these figures were published in WHO’s benchmark Weekly Epidemiological Record (1993). Since these statistics represented less than 1 percent of the cases reported for the Americas as a whole and were dwarfed by the 212,642 cases in Peru, Venezuela never became an important focus of attention in the international press or in international public health circles. The Regional Epidemiologist for Delta Amacuro officially reported 823 cases of cholera and 12 deaths in the state in 1992 and 1993.<sup>8</sup> Nevertheless, both he and the Director of the Regional Office of Health informed a newspaper, El Diario de Monagas (1993:1), that 1,701 cases of cholera and 49 deaths had been recorded as of 26 January 1993. In an interview that I conducted with him, the Regional Epidemiologist stated that he had initially compiled statistics for all cholera cases. Informed by the National Epidemiologist that the total was far too high, he was instructed to count only cases for which a laboratory confirmation was available—even though no laboratory was available in the state at the beginning of the epidemic and the tubes for taking samples were largely unavailable at the rural clinics in which most patients were treated. Based on systematic interviewing conducted in the delta in 1994 and 1995, Dr. Mantini Briggs and I estimate that some 500 people died in the fluvial area in 1992-93.

On the other hand, many of the narratives that circulated in delta communities and among activists placed the epidemic precisely in this historical context. Global commerce, the effects of the economic crisis, and changes in government policies—including cutbacks in health services—were directly connected to the advent of the outbreak and to its virulence in the region. In popular discourses in many regions of Venezuela, talking about the epidemic became a site in which the adoption of neoliberal policies by the government of President Carlos Andrés Pérez as well as issues of corruption and bureaucratic inefficiency were mapped and interpreted. Some accounts, told on the streets of Tucupita as well as on those of Caracas and other major cities, suggested that

official proclamations of a cholera epidemic amounted to a smokescreen that was invented in order to take people's minds off the political and economic crisis and prompt them to halt their protests.

#### THE ELUSIVE AND DANGEROUS PLACE OF CHOLERA IN MODERNITY

Stigma, writes Erving Goffman (1963), centrally involves external marks—"defective" physical, linguistic, or behavioral features that are deemed to provide visual signs of a pervasive internal failing. From the nineteenth century to the present, the horrible symptoms of cholera have marked bodies indelibly as bearers of all that is antithetical to the modern world—dirt, ignorance, poverty, backwardness, and the past. Cholera is the quintessential premodern disease. In Delta Amacuro, indígenas were branded as threats to social and sanitary order, a stigma that antibiotics, quarantine, or even flight to the mainland could not erase.

But cholera stigma is even harder to contain than Vibrio cholerae. The people who labeled their neighbors or the individuals supervised by their institutions as choleric tend to catch the stigma themselves. While officials in Caracas could place cholera on the backs—or in the guts—of neighboring countries or those of poor and indígena citizens, Venezuela as a whole, including its state institutions, was thrust into the chronotopic space of cholera by international epidemiologists. No one seems to be immune. From colonial medicine in India (see Arnold 1993) and Africa (see Vaughan 1991) to AIDS in the 1980s in Haiti and the United States (see Farmer 1992; Epstein 1996), epidemics of infectious diseases fuel narratives and institutional practices that circulate denigrating images, (re)creating systems of social inequality all along the way. While this process may help threatened institutions fend off attacks by displacing responsibility for epidemics, my analysis suggests that it ultimately benefits no one. If we are to contribute to dismantling it, we will have to develop strategies for grappling with how legitimacy is invested in modernity, institutions, and cultural reasoning.

The accounts regarding cholera in Latin America, Venezuela, and Delta Amacuro produced by journalists, public health officials, physicians, politicians, and others largely constructed the epidemic as a problem that can be contained within simple modernist

narratives. The distribution of cholera defines a dichotomy between modernity and its opposite, whether the latter is labeled premodern, traditional, indígena, uncivilized, Third World, or what have you. Cholera is constructed as a disease that clings to and kills the premodern, seeking out the people who are most lacking in the cognitive, social, and material benefits of modernity, the folks who purportedly lack the knowledge, will, or resources to help themselves. People who live on the modern side of the divide consider themselves to be in possession of the epistemologies, technologies, resources, and determination needed to help cholera victims—at the same time that they criticize rival members of the modern camp for lacking at least one of these elements. Premodern subjects are deemed to be incapable of taking advantage of modern initiatives or even actively resisting them; by failing to embrace modernity when the stakes are so high, they purportedly prove that they will never become part of the modern world, at least not anytime soon.

But the relationship between modernity and cholera turns out to be invented, fragile, and dangerous. Delta Amacuro officials saw themselves as representing the forces of modernity, waging heroic struggles against politicians, merchants, indígenas, and other characters who, to varying degrees, represented a traditional, backward world. But tools that played a key role in their strategies, such as quarantines, cordons sanitaires, and chemoprophylaxis (treating entire communities with antibiotics), are depicted by officials at PAHO and WHO as the quintessence of premodern, irrational responses to cholera epidemics. Alternatively, take the example of the foremost public health official in Delta Amacuro at the time of epidemic. At the same time that she blamed the epidemiology of cholera in the delta on indígenas' beliefs in spirits and consultation with “shamans,” she is widely believed to be a practitioner in the spirit possession “court” of María Lionza. Will the real modern subject please stand up? A 60 Minutes report aired in 1994 echoed US Army physicians in characterizing WHO as being “stuck in some sort of time warp” for refusing to use cholera vaccine in Peru (CBS News 1994:4), suggesting that no individual and no institution is immune from being cast outside the mantle of the modern.

Epidemiologists of cholera often assert that the cholera epidemics of the nineteenth

century gave rise to a sanitary revolution that took place in Europe and the United States. Claiming that Latin America, Africa, and parts of Asia failed to join this revolution provides a basis for both explaining why cholera persists in those regions and for calling on governments to make sanitary reforms. Officials in Tucupita and Barrancas often applauded the beneficial effects of the epidemic in providing them with new visibility and clout in their efforts to bring modern sanitation and hygiene to the region and in discrediting indígena “witches.” Nevertheless, responses to the epidemic, regardless of the resources and energy they brought to the delta, were never intended to be more than short-term; no serious efforts were undertaken to change health and sanitary infrastructures or to provide systematic health education in the fluvial region, let alone to address issues of institutional racism, economic oppression, or a lack of respect for political and human rights. The long-term impact of institutional responses to the epidemic significantly worsened social, economic, and health conditions in the delta.

A more penetrating reading of nineteenth century cholera epidemics in the United States and Europe suggests the fallacy of the sanitary revolution narrative. Barua (1992:24) asserts that the intense concern with cholera in the nineteenth century “led to rapid sanitary reforms in many countries,” and Tauxe suggests that while Latin America is headed downhill with regards to sanitation, “cholera was the principal impetus driving the reconstruction and modernization of sanitary systems in Europe and the United States.”<sup>9</sup> Pelling (1978) argues that cholera epidemics were probably more of a distraction from than a stimulus to sanitary reform. Evans (1987) and Rosenberg (1962) suggest that few institutional responses to the disease had any lasting impact. Nineteenth-century sanitary reforms were part of broad historical processes that involved the ascendance of free-market economics and state regulation of the lives of the poor. Moreover, assertions that the sanitary revolution has not yet come to Latin America (see Tauxe 1992:43) erase the importance of sanitary reform movements in Latin America, which began in the eighteenth century (see for example Alchon 1992). We might suggest that epidemiologists read García-Márquez’s (1985) Love in the Time of Cholera to see how deeply sanitary reform has shaped Latin American perceptions of class and history. I do not mean to suggest that public health professionals consciously invented this historical narrative in

order to cover their tracks; the difficulty is rather that the story is so deeply ingrained in professional identities and forms of authority. If public health officials genuinely wish to improve sanitary infrastructures and overall health conditions, the rhetorical and political locus of such efforts cannot be based on the “positive effects” of the terror associated with cholera.

As I noted above, the stories told by many people who survived the epidemic connect cholera and modernity in a very different way; in these narratives, cholera is the quintessential disease of modernity. If we equate modernity with the penetration of the nation-state into the delta and the lives of its residents and resource exploitation by national and transnational corporations, then cholera emerged in the historical memory of people in the delta precisely as a part of the experience of modernity. Cholera here becomes, to draw on Jean Franco’s (1986) phrase, a quintessential embodiment of the “violence of modernization.” Just as these narratives can be dismissed as fanciful conspiracy theories, this account of the cholera-modernity connection could be rejected out of hand as reflecting a lack of historical or global knowledge. But this basic shift in how we define cholera socially and politically also brings the history of cholera pandemics into sharper focus. Writers dispute whether Vibrio cholerae 01 was present prior to the nineteenth century, but it is clear that the first half of the nineteenth century witnessed successive pandemics that caused tremendous mortality in the Americas, Europe, Asia, and the Middle East. This was, of course, a period in which modernity reshaped the lives of peoples on all of these continents through colonialism, resource extraction, and plantations on the periphery and urbanization, industrialization, and the economic exploitation of workers in the core, to use Wallerstein’s (1974) terms. A central feature of the expansion of economic, social, and political modernity during the nineteenth century was the emergence of more extensive systems of transportation and travel. In short, a critical reading of the historical literature could also form the basis for characterizing cholera pandemics not as features of the premodern world but as products of modernity itself. Moreover, modern sanitation promoted cholera epidemics through the development of systems for extracting feces from the sites in which growing urban populations were depositing them, transporting wastes, and depositing them in rivers

and oceans. Rockefeller (1998) argues that the emergence of cholera pandemics in the nineteenth century can be traced to the installation of flush toilets; overflowing cesspools were then connected to the open sewers of city streets and eventually to waterways. While it would therefore be tempting to simply reverse the fundamental premise on which cholera stories rest by declaring that cholera is caused by modernity and sanitation, such a move would only attempt, probably fruitlessly, to reposition the modern/premodern dichotomy and thus to sustain modern constructions of inequality.

The sanitary revolution narrative pretends to be egalitarian and inclusive, to suggest that all people can become part of a modern world in which diseases such as cholera will be part of the past. The eradication of smallpox, of course, is the great success story here. But sanitation rather functions as a discourse of exclusion and hierarchicalization, of asserting the scientific, moral, political, and social superiority of the individuals, communities, nations, and continents who have the resources to eradicate the conditions that provide good environments for cholera and other diarrheal diseases, tuberculosis, malaria, and so forth. Here, talk of modern sanitation and hygiene provides a synecdoche for discourses of modernity in general; Stallybrass and White (1986) argue that the opposition between hygiene and filth played a crucial role in defining modern subjects in the nineteenth century. Questions of cholera and sanitation thus lend themselves to a view of modernity as revolving around pervasive practices of exclusion. As we enter the twenty-first century, discourses of cholera, sanitation, hygiene, and public health help to sustain the egalitarian promise of modernity as well as practices of exclusion, which to have never been so hard at work.

#### CULTURAL REASONING, GLOBALIZATION, AND THREATENED INSTITUTIONS

In stressing how the daily activities of public health officials promoted the virulence of cholera narratives at the same that they sought to control the disease, my goal has not been to argue that we can simply pin the blame on them or on national and international institutions. To the contrary, adequate analyses and effective interventions must be based on in-depth understandings of how these institutions operate, the complex and contradictory range of discourses and ideologies that are mustered in sustaining

them, and the new vulnerabilities that they face. Globalization and growing social inequality are presenting new challenges to the nation-state; institutions are charged with the job of generating ideologies and practices that construct inequality in ways that transfer responsibility from the state and corporations onto the shoulders of the growing ranks of the poor. On the one hand, this deepening and extension of social inequality opens up vast opportunities for the extension of regimes of surveillance and control as well as for the legitimization of institutional authority, including that of legal, public health, social service, educational, and other agencies. In the United States, this process is apparent in the expansion of the prison-industrial complex and in the institutional schemas devised to reduce or end social program targeted for the poor; racializations of subject populations and legitimizing rhetorics of culture proliferate in this context.

At the same time, however, neoliberal policies, space-time compression, and the growing hegemony of corporations and financial sectors are transforming nation-states and the types of power and control that they can exert. Industrialized countries, corporations, and such international organizations as the World Bank, International Monetary Fund, and (at present) the World Trade Organization exert especially forceful pressures on so-called peripheral states. Venezuela provides a striking example; a stunning and rapid rise in poverty and social inequality has called the legitimacy of democratic institutions into question. Even powerful and entrenched bureaucracies cannot take their access to power and resources or the legitimacy of their practices for granted—or even the ability to pay civil servants. Globalization also fosters the worldwide circulation of discourses of human rights and access to national and international NGOs, thereby providing subaltern subjects with access to discourses and organizations that can challenge the epistemologies and practices of state agencies.

For public health institutions in Latin America, the cholera epidemic embodied this Janus-faced process in a very concrete and direct fashion. I pointed above to the centrality of cultural reasoning in institutional lines of defense. The racialization of cholera in Delta Amacuro increased the value of cultural reasoning in representing cholera and the power of cholera in representing social inequality. But the nature of cultural reasoning and the effects of globalization on institutions suggests why this

connection fits so well. Theodore Porter (1995) argues that the adoption of statistics by institutions is less adequately described as a Foucauldian extension of hegemonic authority than as a defensive strategy forced upon bureaucracies in the face of threats to their legitimacy. To paraphrase Shakespeare, so let it be with culture. As globalization simultaneously presents institutions with new possibilities for social control and a political-economic dynamism that could threaten their legitimacy, cultural reasoning provides an excellent means of playing both ends against the middle. Culture is a liberal discourse that institutions can perform, even as facets of their everyday practices, in claiming to be sensitive to the characteristics, needs, and rights of the populations they serve. In Venezuela and elsewhere, officials can even adopt an anti-racist, anti-imperialist, and anti-institutional stance that would seem to align them with the subaltern and against the nation-state. Cultural reasoning thus provides an excellent line of defense against scrutiny by rights activists.

At the same time, cultural reasoning provides a fertile ground for re-imagining, extending, and naturalizing schemes of social inequality. It supplies synecdochic logics that facilitate the construction and imposition of images and frameworks for particular cases and their extension to all members of a population—all “Warao” become reservoirs of cholera. Such rhetorics provide institutions with an excellent means of capitalizing on the opportunities and uncertainties presented by globalization. Once they have been put in place, these cultural rhetorics can be called upon for service in future contexts and for diverse purposes, as in the use of cholera stigma in paving the way for the “Oil Opening” that permits petroleum exploration and exploitation by transnational corporations in the delta.

Tracing cholera narratives provides insight into how cultural reasoning penetrates institutional rhetorics and practices. In some cases, anthropologists and sociologists worked within or were temporarily assigned to public health agencies. At the same time, the political economy of academic institutions is important; both the displacement of professionals who do not find employment in their own discipline into other fields, the blurring of boundaries between fields, and the expansion of multi- and interdisciplinary modes of inquiry facilitates the circulation of talk about culture. Transmission of cultural

reasoning takes place as public health professionals read published works by anthropologists. In Delta Amacuro, inter-institutional task forces, such as the Anti-Cholera Committee, placed individuals bearing contrastive epistemologies and practices into the same rooms. Informal discussions between professionals that took place in the course of institutional life were of crucial importance in the delta. The Indigenous Census took anthropologists throughout the delta in 1992, and they often stayed in the homes of physicians. One physician reported that the week-long stay of a Caracas-based anthropologist turned into a mini-course on “Warao culture.” Finally as both anthropologists, public health physicians, and others made declarations to the press, their disciplinarily informed perspectives intersected as they came to shape a public discourse of cholera and culture, thereby fostering the production of hybrid rhetorics. Accordingly, any professional seems to be able to claim the right to speak for culture, even if anthropologists are sometimes granted greater authority here. To be sure, physicians who think they can become amateur anthropologists would be very unlikely to accept anthropologists as amateur colleagues in clinics. This process can result in the circulation of cultural reasoning without citations and thus its objectification both as common knowledge and as institutional discourse itself.

As representations of the cholera epidemic demonstrate, the images generated by cultural reasoning travel well between institutions. Similar depictions of indígenas were used by public health and legal institutions, the regional government, the Regional Office of Indigenous Affairs, and the press. Similar images appeared in Caracas in newspapers and on television, in national public health offices, and in government responses to the arrival of health refugees. But culturally based images of populations at risk for cholera formed part of the way that international epidemiologists in the United States and Europe, including such influential agencies as PAHO, sought to account for the Latin American epidemic. Two properties of cultural discourses seem to promote such widespread circulation. First, many of these images are derived from widely distributed stereotypes. While knowledge of cholera may have changed a great deal since the early nineteenth century, stigmatizing portrayals of cholera patients are remarkably stable. Since these are some of the images that helped to define the meaning of modernity in the

nineteenth century, it is little wonder that they would be useful in helping institutions characterize themselves as modern; as Weber (1968) suggested long ago, claiming the mantle of the modern lies at the heart of bureaucratic projects. Second, the anthropological basis of cultural reasoning helps to transform widely distributed stereotypes into what seem to be features that emanate empirically from these populations' own self-conceptions and customs and to elevate them to the status of a scientific discourse of culture. At the same time that they are scientized, these representations become objectified, that is, bounded, encapsulated, and decontextualized, severed from the interests, power relations, and processes that produced them.

This is not to say that such images are identical no matter where they are found. At the same time that it can circulate freely within, between, and beyond institutions, cultural reasoning adapts to the specific epistemological and pragmatic contours of the particular sites in which it is used. Cultural images are shaped by the economy of inequality, including race, ethnicity, class, gender, sexuality, and nationality, of the sites in which they are recontextualized—at the same time that they help to extend and reconfigure these economies. This is why images that had already circulated through the Western hemisphere took on such a virulent character when they entered the brutal economy of indígena/criollo racialization in Delta Amacuro state. As they enter a particular institution, cultural discourses create rough parallels between the epistemologies and practices associated with the domain that it regulates and projected cultural beliefs and practices. Public health officials could point to religious, ritual, healing, kinship, culinary, and hygienic practices in Warao communities as corresponding, in negative or inverted terms, to those recommended by medical practitioners, and they expounded on the preparation and consumption of crabs, the mode of securing and storing water, cultural practices of bodily elimination, and the like—activities that related directly to epidemiological hypotheses regarding the routes of transmission of cholera. The anthropologist who submitted an affidavit on behalf of the young indígena charged with infanticide could draw (without citation) on my own work on dispute mediation in the delta (see Briggs 1988, 1996) in suggesting that the monikata constituted an “ethnolegal system” that could be directly compared to—and certainly

contrasted with—the Venezuelan legal system. This example forces me to reflect on how my research on “Warao” discourse and culture played a role in producing and circulating the forms of cultural reasoning that I am tracing here. By virtue of its ability to incorporate practically any facet of social life, cultural reasoning provides a powerful institutional mechanism for racializing social forms and relations that had previously not been imbued with racial meanings (or in extending and transforming existing racial schemas).

The illusion of boundedness, homogeneity, and singularity associated with what are seen as coherent, empirically based views of indígena culture is constructed through the management of profound epistemological contradictions and the juxtaposition of a heterogeneous array of discourses. The double-voiced nature of culture and cultural identities, to use Bakhtin’s (1986[1979]) term, enables institutions to use a scientific language in discovering objective structures that reflect the historically-continuous singularity of a “group,” even as the scientific and liberal dimensions of cultural rhetorics help to conceal the circulation of widely-distributed stereotypes of Others and the central role of institutional structures and agendas in crafting these images for maximum efficacy. Cultural reasoning exploits the tension in the processes of identity formation between self-representation and imposition from without, creating what seem to be racialized identities that have been constructed by indígenas themselves while at the same time covering up the political technologies and everyday racism through which they are imposed. Cultural reasoning operates much like historical narratives, as Hayden White (1978) characterizes them—rhetorics that permit practitioners to imagine social life and then imbue their constructions with the feel of the always already real.

The liberal aura of cultural reasoning is generally sustained by juxtaposing images of “the culture” of dominant sectors, designated in Delta Amacuro as that of criollos or “the national society,” with representations of cultural others. The logic purports to be that of a symmetrical opposition, two equally systematic, cohesive, and integrative cultures, each containing legal, religious, moral, culinary, and other norms—which contrast radically on every axis. But, as Derrida (1974[1967]) warns us, these sorts of dichotomies often contain an implicit asymmetry within them. Here “Western culture” is

deemed to embody modernity and science, while “indígena culture” becomes their very antithesis.

Juxtaposed images presented on a cholera prevention pamphlet produced by the Venezuelan National Guard for distribution in the delta provide a striking visual representation of this supposed symmetry (see Figure 1). The two cultures seem to be quintessentially embodied in the contrast between the well-groomed, bespectacled, confident figure of the military physician and the racialized image of the prototypical indígena (who bears no resemblance to any residents of the delta I have ever met). But the two figures are far from parallel. While the physician seems to appear from nowhere, to need no social or environmental context to locate him and to imbue his words with authority, the indígena is framed by a rural landscape. While the physician dominates the frame and looks the viewer in the eye, the indígena stands back within the frame and looks at the ground. Perhaps most significantly, the physician speaks, naming the disease and the symptoms (vomiting and stomach pain) that the man is experiencing, while the indígena is rendered mute. As I suggested above, claims to the mantle of the modern have stood at the center of practices for creating and legitimating social inequality since the seventeenth century. When racial constructions masquerade as cultural difference, practices of exclusion—which include structural violence of many forms—can be presented as liberal responses to problems that spring directly from the culture of excluded populations.

Tracing the role of cultural reasoning in institutions can help us address a crucial question regarding the effects of globalization on poor populations of color. Appadurai (1996) argues that globalization is producing new modes of inclusion, suggesting that deterritorialization and denationalization disrupt centralization of control over global flows of capital, people, goods, culture, and information. He thus suggests that the US no longer dominates “a world system of images but is only one node of a complex transnational construction of imaginary landscapes” (1996:31). Appadurai’s vision of globalization is thus one of a global egalitarianism, in that even the poor and powerless can participate actively in shaping widely distributed practices of the imagination. At the same time, “the task of producing locality . . . is increasingly a struggle in the wake of

globalizing forces” (1996:189); nevertheless, people can recover agency through a process of “indigenization” that was deployed in resisting colonialism (1996:90). Other writers seem to view globalization as largely exclusionary, as exacerbating social differences based on access to capital, commodities, information, and culture. Michel-Rolph Trouillot (1991) has pinpointed a key issue here in a brief but highly suggestive passage. Insofar as a universal transition is postulated from “modern” to “postmodern” or from “national” to “deterritorialized” ideologies and social forms, what are the implications for social segments that were deemed to have failed to be incorporated into modern social, cultural, and economic patterns? If this supposedly universal stage of globalized, postmodern culture is tied to questioning the “metanarratives” and cultural premises of modernization, it would seem to exclude people who never gained access to progress and modernity. Zygmunt Bauman (1998) argues that the production of social fragmentation, differentiation, and inequality so fundamental to globalization fixes some people in space and restricts access to the globally circulating capital and culture that others enjoy; getting localized while others get globalized “is a sign of social deprivation and degradation” (1998:2). Roland Robertson (1995), on whom Bauman relies, suggests that this localization is imposed, thereby producing a loss of agency and freedom, creating passive local viewers of global actors.

In the end, I do not see either picture as being entirely adequate. Delta residents are not excluded from modernity or globalization. Indeed, they seem to have a greater capacity for connecting the dilemmas they face in their own lives and localities with global forces and processes than the politicians, public health officials, anthropologists, development specialists, missionaries, and others who claim the right and duty to bring the indígenas into the modern world. The cholera narratives told by many delta residents provide penetrating analyses of the global circulation of power and capital, and they can be read as creative and critical rereadings some of the metanarratives of modernity and postmodernity. But, at the same time that the Persian Gulf War, Rambo, Bill Clinton, and millions of other mediated images make it into the delta and are critically received and remembered, delta residents have little control over whether or not their alternative readings of cholera, poverty, neoliberal policies, racism, oil wells, human rights abuses,

land expropriation, and the like make it into the public sphere and out of Delta Amacuro state—and they seldom do.

Cultural reasoning had supposedly extirpated biology from constructions of difference. But public discourses of culture can always get indexically connected with the categories that emerge in private conversations, where bald racism can surface. In conversations between public health employees, projections of the death by cholera of the entire *indígena* population due to weak biological constitutions as well as intractable ignorance and stupidity were common. When exchanged over coffee and framed as humor, such remarks seem permissible, all in good fun. As Jane Hill (1995) argues, however, the boundaries between contexts constructed as public and private are leaky. Such statements circulate beyond these settings, often repeated by overhearers who are upset by such bald racism. M. M. Bakhtin (1981) and Volosinov (1973[1930].) argue that tropes carry their own histories along as baggage. Representations that are framed as scientific characterizations of culture thus often carry other, far less liberal characterizations of difference within them, however hidden and fragmentary they may be. Even when difference is imagined in liberal, cultural terms, the echo of biological reasoning and bald racism is thus often discernible. When the echo of other schemas for constructing and regulating difference are faintly audible, they continue to shape the meaning of even purportedly objective depictions and to present new possibilities for their appropriation in racial projects. During a time of rapid expansion—both of capital and of social inequality—the resulting superimposition of multiple ideologies and practices for remapping inequality are being widely exploited.

How can we begin to imagine modes of disrupting this process? Recall the calls for action sounded by such influential writers on emerging and reemerging diseases as Garrett (1994) and Wills (1996). They urge a more “rational” approach for containing the global spread of microbes, one that centers on controlling population growth and environmental degradation. Our journey around the world on the back of cholera discourse prompts a bit of skepticism when white journalists and scientists in the United States and Europe create reformist visions of this sort. Invocations of rationality, modernity, and global cooperation tend to augment hierarchies of knowledge, expertise,

and authority, thereby inviting new rounds in an old game in which people at the center deem populations on the so-called periphery to be less rational, modern, or disinterested. This type of reformism, as we have seen, only makes things worse, not only for the people who suffer most acutely from these infections but for everyone. We can, on the other hand, respond to the anthropological call to represent the local, classically expressed by Clifford Geertz (1985). Kleinman and Kleinman (1996:18) suggest that disrupting the cultural appropriation of social suffering can only be achieved “if these local worlds are more effectively projected into national and international discourses on human problems.” This suggestion seems to suffer from both epistemological and political fallacies. As Zygmunt Bauman (1998) argues, getting characterized as local, fixed in space and culture while others get globalized becomes “a sign of social deprivation and degradation” (1998:2); Richard Bauman and I have argued that this reciprocal process has played a fundamental role in shaping modernity and social inequality since the seventeenth century (1999).

My analysis of representations of the cholera epidemic suggests that these “local worlds” are in any case a figment of the imaginations of people who claim to be “global.” What Leslie Sklair (1995[1991]), Zygmunt Bauman (1998), Roland Robertson (1995), and many other students of globalization do not seem to appreciate sufficiently is that both localization and globalization, construed as opposing forces, are as much powerful illusions as social processes. Just as the “local world” of cholera patients in the delta is shaped by representations of the Gulf War and the oil wells operated by BP Amoco, the narratives and practices of WHO officials are constrained by the local institutional and political worlds they inhabit. Moreover, global representation of local cultural and social worlds is precisely what epidemiologists present in their discussions of cholera and other infectious diseases, drawing on socially positioned and politically interested images of inequality; journalists are engaged in this project right alongside them. While anthropologists argued from the time of Ruth Benedict (1934) that they can place scientific descriptions of local worlds on global public stages, anthropologists have not met with a great deal of success in recent competitions for rights to represent either culture or the local. The solution, I would argue, does not lie in producing more

authoritative or sophisticated or scientific definitions of culture or modes of cultural analysis; these formulations are likely to be appropriated as more powerful institutional representations of social inequality.

One thing that, as I see it, can and clearly needs to be done is to challenge the objectification of social images in epidemiology, demography, and social science in general. We must insist on keeping images of social inequality linked to the social, political, and historical circumstances in which they are produced, to keep “the representation as contiguous with that being represented and not suspended above and distant from the represented,” as Michael Taussig (1992:10) puts it. We must continue to expose and challenge those master oppositions, such as modernity and its opposites, global and local, and science and superstition, particularly as they are used in launching claims to modernity, rationality, universality, and thus authority and power while at the same time circulating stigma, blame, and images of premodernity, irrationality, and locality through institutional and political circuits. In supporting the struggle of the poor to secure access to health, legal protection, education, and economic wellbeing, we can challenge institutional responses that buttonhole structural violence into narrow biomedical, legal, economic, or demographic slots, thereby sustaining perhaps the most deadly fiction of all—the notion that social justice can be achieved without uprooting the way that wealth and human dignity are distributed in accordance with hierarchies of race, class, gender, sexuality, and nation. Dipesh Chakrabarty (1992:21) writes: “Nowhere is this irony—the undemocratic foundations of ‘democracy’—more visible than in the history of modern medicine, public health, and personal hygiene, the discourses of which have been central in locating the body of the modern at the intersection of the public and the private (as defined by, and subject to negotiations with the state).” I have argued here that discourses of culture are playing an ever more central role in sustaining and extending these undemocratic foundations. Locating the institutional sites in which they are deployed and challenging the liberal and scientific frame that surrounds them must accordingly be incorporated into the critical practices that are needed to counter the current expansion of new and old forms of social inequality.

## NOTES

---

<sup>1</sup> My investigation of the cholera epidemic was undertaken jointly with Clara Mantini-Briggs, MD, a Venezuelan physician; it was funded by the John Simon Guggenheim Memorial Foundation, the National Science Foundation, the Social Science Research Council, and the Wenner-Gren Foundation for Anthropological Research, Inc. I was afforded an ideal environment in which to write about the epidemic by the Woodrow Wilson International Center for Scholars. I wish to thank anonymous reviewers for Comparative Studies in Society and History for comments on a previous draft and reactions by Iain Boal, Veena Das, Steven Epstein, Ludmilla Jordanova, Randall Packard, and Charles Rosenberg. Some parts of this essay appeared in Working paper series number 239, Latin American Program, Woodrow Wilson International Center for Scholars, Washington, DC (1999).

<sup>2</sup> See Asad (1973), Clifford (1988), Fabian (1983), Paredes (1977), Romano-V (1968), and Trouillot (1995).

<sup>3</sup> See also DeBenedictis (1992).

<sup>4</sup> See for example Daye (1997).

<sup>5</sup> Dr. Jacobus de Waard conducted a study of tuberculosis in the delta under the auspices of the Instituto de Biomedicina in Caracas; he reported this figure in an interview conducted in Caracas on 2 July 1999.

<sup>6</sup> In the remainder of the text, I refrain from placing “Warao,” “the Warao,” “the criollos,” and similar expressions in quotation marks in keeping with accepted editorial practices. Nevertheless, I ask readers to bear in mind that my use of these terms does not imply that they refer to bounded, discrete social groups; my analysis suggests that dividing delta residents into discrete and non-overlapping “indigenous” and “non-indigenous categories is less a reflection of a pervasive and elementary social difference than a tool for imposing racial categories and the forms of social inequality that go with them.

<sup>7</sup> My thanks to Francisco Armada, MD for his discussion of this point (personal communication, 1999).

---

<sup>8</sup> This information is contained in a typescript report that is available in the Office of the Regional Epidemiologist, Ministry of Health and Public Assistance, Tucupita, Delta Amacuro.

<sup>9</sup> Here Marwick (1992:1314) is paraphrasing a statement by Tauxe.

## REFERENCES

- Alchon, Suzanne Austin, 1992, 'Disease, Population, and Public Health in Eighteenth-Century Quito,' in "Secret Judgments of God": Old World Disease in Colonial Spanish America, Noble David Cook and W. George Lovell, eds., pp. 159-82. Norman: University of Oklahoma Press.
- Anderson, John, 1992, 'Cholera in the Nineties,' CDC Briefs, Vol. 3, No. 4:1-2.
- Appadurai, Arjun, 1996, Modernity at Large: Cultural Dimensions of Globalization. Minneapolis: University of Minnesota.
- Arnold, David, 1993, Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India. Berkeley: University of California.
- Asad, Talal, ed., 1973, Anthropology and the Colonial Encounter. New York: Humanities.
- Bakhtin, M. M. 1981. The Dialogic Imagination: Four Essays, Caryl Emerson and Michael Holquist, tr., Michael Holquist, ed. Austin: University of Texas Press.
- \_\_\_\_\_, 1986[1979], 'The Problem of Speech Genres,' in Speech Genres and Other Late Essays, Caryl Emerson and Michael Holquist, ed., pp. 60-102. Austin: University of Texas Press.
- Balibar, Etienne, 1991, 'Is There a "Neo-Racism"?' in Race, Nation, Class: Ambiguous Identities, by Etienne Balibar and Immanuel Wallerstein, pp. 17-28. London: Verso.
- \_\_\_\_\_, 1995, 'Culture and Identity (Working Notes), in The Identity in Question, John Rajchman, ed., New York: Routledge.
- Barrios, Asdrubal, 1991, 'Alertan sobre posible estallido de cólera en Caracas,' El Nacional, 23 February 1991, p. C-3.
- Barua, Dhiman, 1992, 'History of Cholera,' in Cholera, Dhiman Barua and William B. Greenough III, eds., pp. 1-36. New York: Plenum Medical.
- Bauman, Richard, and Charles L. Briggs, 1999, 'Modernizing Discourse: Language Ideologies and the Politics of Inequality,' ms. In possession of authors.
- Bauman, Zygmunt, 1998, Globalization: The Human Consequences. New York: Columbia University Press.
- Benedict, Ruth, 1934, Patterns of Culture. Boston: Houghton Mifflin.

- Bhabha, Jacqueline, 1996, 'Embodied Rights: Gender Persecution, State Sovereignty, and Refugees,' Public Culture, Vol. 9:3-32.
- Bracamonte, Amilcar, 1991, '303 Casos de cólera detectados en el País,' El Mundo, 10 August 1991, p. 7.
- Briggs, Charles L., 1988, 'Análisis sociolingüístico del discurso Warao: notas preliminares sobre las formas seculares,' Montalbán, Vol. 20:103-20.
- \_\_\_\_\_, 1992, "'Since I Am a Woman, I Will Chastise My Relatives": Gender, Reported Speech, and the (Re)production of Social Relations in Warao Ritual Wailing,' American Ethnologist, Vol. 19:337-61.
- \_\_\_\_\_, 1993, 'Personal Sentiments and Polyphonic Voices in Warao Women's Ritual Wailing: Music and Poetics in a Critical and Collective Discourse,' American Anthropologist, Vol. 95:929-57.
- \_\_\_\_\_, 1996, 'Conflict, Language Ideologies, and Privileged Arenas of Discursive Authority in Warao Dispute Mediation,' in Charles L. Briggs, ed., Disorderly Discourse: Narrative, Conflict, and Social Inequality, pp. 204-42. Oxford: Oxford University Press.
- \_\_\_\_\_, 1997, 'Notes on a "Confession": On the Construction of Gender, Sexuality and Violence in an Infanticide Case,' Pragmatics, Vol. 7, No. 4:519-46.
- Briggs, Charles L. and Clara Mantini Briggs, 1997, "'The Indians Accept Death as a Normal, Natural Event"; Institutional Authority, Cultural Reasoning, and Discourses of Genocide in a Venezuelan Cholera Epidemic,' Social Identities Vol. 3, No. 3:439-69.
- \_\_\_\_\_, 2000, "'Bad Mothers" and the Threat to Civil Society: Narrating Sex, Race, and Class in an Infanticide Trial,' Law and Social Inquiry (forthcoming).
- Campisi, Jack, 1991, The Mashpee Indians: Tribes on Trial. Syracuse, NY: Syracuse University Press.
- CBS News, 1994, 'Why?' Transcript of text for segment of 4 December 1994 Program. Xolume XXVII, Number 13. Livingston, NJ: Burrelle's Information Services.
- Chakrabarty, Dipesh, 1992, 'Postcoloniality and the artifice of history: Who speaks for Indian pasts.' Representations, Vol. 37:1-26.
- Clifford, James, 1988, The Predicament of Culture: Twentieth-Century Ethnography, Literature, and Art. Cambridge, MA: Harvard University Press.

- Coronil, Fernando, 1997, The Magical State: Nature, Money, and Modernity in Venezuela. Chicago: University of Chicago Press.
- Coronil, Fernando and Julie Skurski, 1991, 'Dismembering and Remembering the Nation: The Semantics of Political Violence in Venezuela,' Comparative Studies in Society and History, Vol. 33, No. 2:288-337.
- Crenshaw, Kimberle, 1989, 'Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics,' The University of Chicago Legal Forum, 1989, pp. 139-68.
- \_\_\_\_\_, 1991, 'Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color,' Stanford Law Review, Vol. 43:1241-99.
- Cueto, Marcos, 1997, El regreso de las epidemias: Salud y sociedad en el Perú del siglo XX. Lima: IEP Instituto de Estudios Peruanos.
- Daye, Douglas D, 1997, A Law Enforcement Sourcebook of Asian Crime and Cultures: Tactics and Mindsets. Boca Raton, Flor.: CRC Press.
- DeBenedictis, D.J., 1992, 'Judges Debate Cultural Defense: Should Crimes Acceptable in an Immigrant's Homeland be Punished?' American Bar Association Journal, Vol. 78 :23.
- Delaporte, Francois, 1986, Disease and Civilization: The Cholera in Paris, 1832, Arthur Goldhammer, tr. Cambridge, Mass.: MIT Press.
- Derrida, Jacques, 1974[1967], Of Grammatology, Gayatri Chakravorty Spivak, tr. Baltimore: Johns Hopkins University Press.
- Dunn, Frederick L., and Craig R. Janes, 1986, 'Introduction: Medical Anthropology and Epidemiology,' in Anthropology and Epidemiology, Craig R. Janes, Ron Stall, and Sandra M. Gifford, eds. Dordrecht: D. Reidel.
- El Diario de Monagas, 1993, "1701 casos de cólera con 49 defunciones." 26 January 1993, El Diario de Monagas, p. 1.
- El Mundo, 1991, 'El cólera es una infección típica de las personas de bajos recursos,' El Mundo, 27 November 1991, p. 13.
- El Nacional, 1991, 'Alerta nacional contra cólera y dengue,' El Nacional, 14 Aug. 1991, p. C-4.
- Epstein, Steven, 1996, Impure Science: AIDS, Activism, and the Politics of Knowledge. Berkeley: University of California.

- Escalante, Luis Manuel, 1992, 'En 40% ha caído el ingreso turístico,' El Universal, 10 June 1992, pp. 2-4.
- Evans, Richard J., 1987, Death in Hamburg: Society and Politics in the Cholera Years 1830-1910. Oxford: Clarendon Press.
- Fabian, Johannes, 1983, Time and the Other: How Anthropology Makes Its Object. New York: Columbia University Press.
- Farmer, Paul, 1992, AIDS and Accusation: Hati and the Geography of Blame. Berkeley: University of California Press.
- \_\_\_\_\_, 1999, Infections and Inequalities: The Modern Plagues. Berkeley: University of California Press.
- Franco, Jean, 1986, 'Death Camp Confessions and Resistance to Violence in Latin America,' Socialism and Democracy, Vol. 2:5-17.
- Gangarosa, Eugene J., and Robert V. Tauxe, 1992, 'Epilogue: The Latin American Cholera Epidemic,' in Cholera, Dhiman Barua and William B. Greenough III, eds., pp. 351-58. New York: Plenum Medical.
- García-Márquez, 1985, El amor en los tiempos del cólera. Bogotá: Editorial Oveja Negra.
- Garrett, Laurie, 1994, The Coming Plague: Newly Emerging Diseases in a World Out of Balance. New York: Farrar, Straus and Giroux.
- Geertz, Clifford, 1985, Local Knowledge. New York: Basic Books.
- Glass, R. I., M. Libel, and A. D. Brandling-Bennett, 1992, 'Epidemic Cholera in the Americas,' Science, Vol. 256:1524-25.
- Goffman, Erving, 1963, Stigma: Notes on the Management of Spoiled Identity. New York: Simon and Schuster.
- Gómez V., Raúl, 1991, 'En peligro étnia waayu por aparición del cólera en le Estado Zulia,' El Mundo, 5 December 1991, p. 32.
- Hausmann, Ricardo, 1995, Dealing with Negative Oil Shocks: The Venezuelan Experience in the Eighties. Washington, DC: Inter-American Development Bank.
- Hill, Jane H., 1995, 'Junk Spanish, Covert Racism and the (Leaky) Boundary Between Public and Private Spheres,' Pragmatics, Vol. 5, No. 2:197-212.

- Hirsch, Susan, 1995, 'Interpreting Media Representations of a "Night of Madness": Law and Culture in the Construction of Rape Identities,' Law and Social Inquiry, Vol. 19:1023.
- Kleinman, Arthur, and Joan Kleinman, 1996, 'The Appeal of Experience; The Dismay of Images: Cultural Appropriations of Suffering in Our Times,' Daedalus, Vol. 125, No. 1:1-23.
- Koptiuch, Kristin, 1991, 'Third-Worlding at Home,' Social Text, Vol. 9:87-99.
- Lévi-Strauss, Claude, 1969, The Raw and the Cooked: Introduction to a Science of Mythology, vol. 1, John and Doreen Weightman, tr. New York: Harper and Row.
- Lipsitz, George, 1994, Dangerous Crossroads: Popular Music, Postmodernism and the Politics of Place. London: Verso.
- Márquez, Gustavo, Joyita Mukherjee, Juan Carlos Navarro, Rosa Amelia González, Roberto Palacios, and Roberto Rigobón, 1993, 'Fiscal Policy and Income Distribution in Venezuela,' in Government Spending and Income Distribution in Latin America, Ricardo Hausmann and Roberto Rigobón, eds., pp. 145-213. Washington, DC: Inter-American Development Bank.
- Marwick, Charles, 1991, 'Like Attacker Probing Defenses, Cholera Threatens US Population from Elsewhere in this Hemisphere,' Journal of the American Medical Association, Vol. 267, No. 10:1314-15.
- Nations, Marilyn K., and Linda-Anne Rebhun, 1988, 'Angels with Wet Wings Can't Fly: Maternal Sentiment in Brazil and the Image of Neglect,' Culture, Medicine, and Psychiatry, Vol. 12, No. 2:141-200.
- Notidiario, 1992a, 'El cólera está matando a los waraos del Delta,' Notidiario, 14 August 1992, p. 12.
- \_\_\_\_\_, 1992b, 'Instalan en Tucupita laboratorio de microbiología,' Notidiario, 19 August 1992, p. 3.
- OCEI (Oficina Central de Estadística e Informática), 1993, Censo Indígena de Venezuela, 1992 (2 vols.). Caracas: Oficina Central de Estadística e Informática.
- Omi, Michael, and Howard Winant, 1987, Racial Formation in the United States: From the 1960s to the 1980s. New York: Routledge and Kegan Paul.

- Packard, Randall M. 1989, White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa. Berkeley: University of California Press.
- Pan American Health Organization (PAHO), 1991, Basic Documents of the Pan American Health Organization. (15th Edition). Official Document No. 240. Washington, D.C.: Pan American Health Organization.
- \_\_\_\_\_, 1992, Pro Salute Novi Mundi: A History of the Pan American Health Organization. Washington, DC: Pan American Health Organization.
- Paredes, Américo, 1977, 'On Ethnographic work among Minority Groups: A Folklorist's Perspective,' New Scholar, Vol. 7:1- 32.
- Pelling, Margaret, 1978, Cholera, Fever and English Medicine 1825-1865. Oxford: Oxford University Press.
- Petrera, Margarita, and Maibí Montoya, 1993, Impacto Económico de la Epidemia del Cólera Peru—1991, Serie Informes Técnicos No. 22. Washington, DC: Programa de Políticas de Salud, Organización Panamericana de la Salud.
- Porter, Theodore, 1995, Trust in Numbers: The Pursuit of Objectivity in Science and Public Life. Princeton, NJ: Princeton University Press.
- Propp, Vladímir, 1968 [1928], The Morphology of the Folktale, Laurence Scott, tr. Austin: University of Texas Press.
- Rimonte, Nilda, 1991, 'A Question of Culture: Cultural Approval of Violence against Women in the Pacific-Asian Community and the Cultural Defense,' Stanford Law Review, Vol. 43:1311-32.
- Robertson, Roland, 1995, Globalization: Social Theory and Global Culture. London: Sage.
- Rockefeller, Abby A. 1998, 'Civilization and Sludge: Notes on the History of the Management of Human Excreta,' Capitalism, Nature, Socialism.
- Romano-V., Octavio, 1968, 'The Anthropology and Sociology of the Mexican-Americans: The Distortion of Mexican-American History,' El Grito, Vol. 2:13-26.
- Rosenberg, Charles, 1962, The Cholera Years: The United States in 1832, 1849, and 1866. Chicago: University of Chicago Press.
- Scheper-Hughes, Nancy, 1992, Death without Weeping: The Violence of Everyday Life in Brazil. Berkeley: University of California Press.

- Sklair, Leslie, 1995[1991], Sociology of the Global System. Second edition. Baltimore: Johns Hopkins University Press.
- SOCSAL (Servicio de Apoyo Local, A.C.), [1998], Registro sociodemográfico warao de Punta Pescador. Photocopy.
- Stallybrass, Peter, and Allon White, 1986, The Politics and Poetics of Transgression. Ithaca, NY: Cornell University Press.
- Swerdlow, David L., Eric D. Mintz, Marcela Rodríguez, et al. 1992, 'Waterborne Transmission of Epidemic Cholera in Trujillo, Peru: Lessons for a Continent at Risk,' The Lancet 340:28-32.
- Taussig, Michael, 1992, The Nervous System. New York: Routledge.
- Tauxe, Robert V. 1992, 'Lessons of the Latin American Cholera Epidemic,' 1992, Atlanta Medicine, Vol. 66, No. 4:41-43.
- Tauxe, Robert V., and Paul A. Blake, 1992, 'Epidemic Cholera in Latin America,' Journal of the American Medical Association, Vol. 267, No. 10:1388-90.
- Trouillot, Michel-Rolph, 1991, 'Anthropology and the Savage Slot: The Poetics and Politics of Otherness,' in Recapturing Anthropology: Working in the Present, Richard G. Fox, ed., pp. 17-44. Santa Fe, NM: School of American Research.
- \_\_\_\_\_, 1995, Silencing the Past: Power and the Production of History. Boston: Beacon.
- United Nations, 1948, Convention on Genocide, GAOR Resolution 260A (III), 9 December 1948, Article II, Geneva.
- Vaughan, Megan, 1991, Curing Their Ills: Colonial Power and African Illness. Stanford, CA: Stanford University Press.
- Volosinov, V.N. 1973[1930], Marxism and the Philosophy of Language, Iadislav Metejka and I.R. Titunik, tr. New York: Seminar Press.
- Wallerstein, Immanuel, 1974, The Modern World-System. New York: Academic Press.
- Weber, Max, 1968, Economy and Society: An Outline of Interpretive Sociology, Guenther Roth and Claus Wittich, eds. New York: Bedminister Press.
- White, Hayden, 1978, Tropics of Discourse: Essays in Cultural Criticism. Baltimore: Johns Hopkins Press.

- Wilbert, Johannes, 1972, 'Tobacco and Shamanistic Ecstasy among the Warao of Venezuela,' in Flesh of the Gods: The Ritual Use of Hallucinogens, Peter Furst, ed., pp. 55-83. New York: Praeger.
- \_\_\_\_\_, 1980, 'Genesis and Demography of a Warao Subtribe: The Winikina,' in Demographic and Biological Studies of the Warao Indians, Johannes Wilbert and Miguel Layrissed, eds., pp. 13-47. Los Angeles: UCLA Latin American Center.
- \_\_\_\_\_, 1993, Mystic Endowment: Religious Ethnography of the Warao Indians. Cambridge, MA: Harvard University Center for the Study of World Religions.
- Wills, Christopher, 1996, Yellow Fever, Black Goddess: The Coevolution of People and Plagues. Reading, MA: Addison-Wesley.
- WHO (World Health Organization), 1993, 'Cholera in 1992/Le choléra en 1992,' Weekly Epidemiological Record/Relevé épidémiologique hebdomadaire 68(21):149-55.
- Wyatt, Gail Elizabeth, 1982, 'The Sexual Experience of Afro-American Women,' in Women's Sexual Experience: Exploration of the Dark Continent, Martha Kirkpatrick, ed. New York: Plenum.
- Zambrano, Alonso, 1991, 'Aumentaron a 67 casos de cólera en la frontera,' El Nacional, 18 November 1991, p. D-6.