

Infant death and interpretive violence in Northeast Brazil: taking bereaved Cearense mothers' narratives to heart

Mortes infantis e violência interpretativa no Nordeste brasileiro: levando em conta as narrativas de mães cearenses enlutadas

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Abstract

This study investigates bereaved mothers' ethnoetiologies of avoidable infant deaths in Northeast Brazil. It critically examines the anthropological debate concerning "selective maternal negligence" as a relevant explanation for high infant mortality, based on an analysis of preexisting data. From 2003 to 2006, 316 ethnographic interviews collected by the author from 1979 to 1989 in six communities in Ceará State were retrieved. Forty-five narratives of fatal illness and death of 56 children < 5 years of age were identified for in-depth analysis. Despite their low income and schooling, grieving mothers constructed their own explanations for early death. The most common causes were infectious-contagious diseases (37.9%) and dehumanized care by the attending health professional (24.1%). No mother reported maternal carelessness, detachment, or negligence. If there is any "disregard" in the context of poverty, it is by the unjust economic, political, and social system and inhumane public health practice which violates their rights as citizens. To characterize a bereaved mother as "negligent", or worse, as accomplices in her child's death, is an act of interpretive violence, unfairly blaming and demoralizing mother-caregivers in Northeast Brazil.

Infant Mortality; Maternal Behavior; Child Abuse

Infant death, maternal agency and accusation

Northeast Brazil has long suffered staggering rates of infant mortality ¹, a trend that persists to this day ². Bereaved mothers seek comfort in popular explanations (ethnoetiologies) to make sense of their child's untimely "departure from this earth" ^{3,4}. Differing from official causes of death ⁴, subjective rationalities are rooted in local moral worlds ⁵. The anthropologist's task of unveiling these cultural interpretations is difficult given their multiple, even antagonistic, significances ⁶. Ethnography is "essentially contestable", reminds Geertz; it is "less marked by perfection of consensus and more by the refinement of the debate" ⁶ (p. 29). Ethnographic monologues are "of little value, since there are no conclusions to be reported, but, a discussion to be sustained" ⁶ (p. 29).

Infant death and maternal agency in Northeast Brazil have been at the epicenter of anthropological debate for more than 20 years. In 1982, Nations ⁷ argued that despite poverty, mothers (parents) in Pacatuba, Ceará pro-actively seek care – against all odds – to save dying infants ⁸. In 1984-1985, Scheper-Hughes ^{9,10} posited, contrarily, that mothers in Ladeiras, Pernambuco, contribute to their infants' deaths ⁹, performing what amounts to survival triage ¹¹. The extremity of poverty, reproductive pressures and "internalization and projection of a psychology of

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want and deprivation”⁹ (p. 544) have a pernicious effect on a mother’s ability to nurture, she claims. Socialized to expect that some offspring will die, she chooses between children, nurturing those seen as more likely to survive, and neglecting those seen, self-fulfillingly, as likely to die. “Maternal selective neglect” is synonymous with “benign neglect”, “masked deprivation” and “passive infanticide”, since “*all these concepts suggest that highly stressed mothers may themselves contribute, indirectly, to the high rates of infant death as a form of pos-partum abortion or family planning*”⁹ (p. 536). Because of a perceived “*basic strangeness*” in infants, they appear as “*an ‘unnatural’ child, an angel of death that was never meant to live*”¹⁰ (p. 306). Mothers emotionally distance themselves, displaying “*expressed disaffection*”⁹ (p. 539), “*indifferent commitment*” or even “*hostile rejection*” of their babies¹⁰ (p. 314). Vital care, food, medicine and affection are withdrawn; mothers are even said to compete with offspring, stealing their food and medicine for themselves¹². Sickly, frail, and passive infants are “*allowed to die ‘a mingua’ that is, without attention, care or protection*”⁹ (p. 541), she alleges. Mothers accept death without shedding a tear “*and few do*”¹⁰ (p. 312). Their post-mortem “*la belle indifférence*”¹⁰ (p. 312) is evidence of tenuous bonds to infants. Maternal “detachment” and “indifference”, she concludes, are “*childhood pathogens*”¹⁰ (p. 292) – as dangerous as any microbes.

Nations & Rebhun’s¹³ 1988 article, *Angels With Wet Wings Won’t Fly: Maternal Sentiment in Northeast Brazil and the Image of Neglect*, rebutted Schepers-Hughes^{9,10}. If any negligence exists in Northeast Brazil, it is *of* – not *by* – poor women. The *etic* term “negligence” is malicious, inferring an intentionality to harm. “Ethnoeugenicis” conjures up images of Nazi-like selective breeding to improve human hereditary traits¹⁴. Depicting mothers as negligent slaves to a “culture of poverty”^{15,16} jades our view of them as competent caretakers – a key, not obstacle, to successful child survival programs¹¹. It shifts the locus of responsibility (and blame) for deaths from social determinants to grieving mothers, de-legitimizing their loss and suffering. Despite criticism, Schepers-Hughes¹⁷ fervently defended “maternal selective neglect” in her 1992, award-winning book, *Death Without Weeping: Everyday Violence in Brazil*.

I am compelled, again, to interrupt Schepers-Hughes’^{9,10,12,17} “ethnographic monologue” with a re-analysis of infant death narratives from Ceará, Brazil. Limiting myself, here, I identify the cause(s) that bereaved mothers attribute to the fatality and, then, scrutinize issues of agency.

Listening to bereaved mothers

Between 2004 and 2007, 316 preexisting ethnographic interviews about child illness, death and survival in Ceará, were retrieved, organized and re-analyzed. Data was collected by the author between 1979-1989 in three rural communities (Pacatuba, Guaiuba, Itapebussú), an urban shantytown (Gonçalves Dias), a re-settlement project (Conjunto Palmeiras) and a fishing village (Pecém), all located less than two hours from Fortaleza, Ceará State capital. The time period and cultural region is similar to Schepers-Hughes’^{9,10}. I identified and analyzed 45 mothers’ (91.1% biological; 6.7% grandmothers; 2.2% adoptive) narratives¹⁸ of fatal disease episodes and deaths of children (< 5 years of age), occurring < 12 months prior to interviews. Informants were poor, mostly illiterate, living in flimsy housing without clean water or adequate sanitation. They experienced 56 deaths of children < 5 years old – 60.7% girls, 39.3% boys; 71.1% died during their first year. Most (77.8%) narrated a single death; 22.2% described 2-3 children’s deaths, including, three pairs of twins.

During exhaustive readings of narratives, 174 ethnoetiologies emerged; they were grouped in 18 categories and ordered along a home-community-hospital pathway. Terminal illness episodes of all 56 deceased children were painstakingly reconstructed, focusing on maternal thinking and reactions. Data interpretation was inspired by Bibeau’s & Corins’s¹⁹ signs, meaning and action methodology. The mother’s symptoms and attributed significance were linked to action taken, or not, to save their infant’s life and to factors she blamed, directly or indirectly, for death. Informants’ anonymity was preserved. The University of Virginia Ethics Committee’s 1979 approval fulfills the Brazilian Ministry of Health’s *Resolution n.º. 196/96*.

Results

Despite low-literacy, all (100%) 45 bereaved Ceará (meaning pertaining to Ceará State) mothers pinpoint at least one cause for their child’s death (Table 1); half (50.9%) implicate two or more of 174 identified ethnoetiologies, or 18 determinants. The most frequent (37.9%) child killer is disease – popular (13.8%) and biomedical (24.1%) – followed (24.1%) by “poor”, even “abusive”, care of sick children by hospital staff; together these two account for more than 60% of causes. A further sixteen ethnoetiologies are identified. No (0%) informant mentions maternal “negligence”, “detachment”, “underinvestment”

Table 1

Ethnoetiology of deaths among children under five, as reported by 45 bereaved mothers with 56 deceased offspring in Ceará State, Brazil, 1979-1989 (n = 174 responses).

	n	%
Political, economic, environmental, nutritional	24	13.8
Corrupt politicians' "policy of contempt" towards poor citizens	2	1.2
Poverty, unemployment, lack of conditions	7	4.0
"Dirty" environment, contaminated water	4	2.3
Violence, accidents, lack of solidarity	3	1.7
Hunger, "fluffy" food, "weakness"	8	4.6
Gender, pregnancy, birth	27	15.5
Women's "hassled, hurried" lives	6	3.5
Husband's authority, threats, wife's submission	2	1.2
"Worrisome" pregnancy, premature delivery, "birth weakness"	14	8.0
Lack of breastfeeding, "dry breast"	5	2.9
Popular and biomedical diseases	66	37.9
Popular illnesses (evil eye, fright, <i>doença de criança</i> , etc.)	24	13.8
Biomedical diseases	42	24.1
Public health services	13	7.5
"Untrustworthy" quality of medical care	3	1.7
Blocked access to care	10	5.7
Health professionals' caretaking	42	24.1
Problems with medical diagnosis/prognosis	13	7.5
Medical staff's "poor care", "abuse", "taunting" of sick child	17	9.8
Lack of medications/harmful drug effects	8	4.6
Premature hospital release of sick child	4	2.3
Spiritual	2	1.2
Divine destiny	2	1.2
Total	174	100.0

or "ethnoeugenic neglect" as killing their, or any, infant. Death discourse exonerates mothers of blame: "I did everything I could to raise her (...) took the most care in the world (...) God is my testimony!". Two (4.4%) express guilt, albeit ironically; one for disobeying her husband's orders *not* to hospitalize; another, for consenting to surgery *against* her own best judgment: "I should've let the doctor operate (...) Before going into the operating room, she even waved bye-bye with her little hand (...) before dying!". There follows a series of narrative excerpts describing the 18 deadly determinants mothers identified.

Ethnoetiology of infant death

Corrupt politicians, and their "policies of contempt" for poor citizens, are blamed for deaths (1.2% of etiologies). Rita, a bright, 38-year-old factory worker said her 11-month-old son died "a *mingua*" for lack of attention from authorities. "If politicians fill-up their own pockets, spend money,

enjoy life, travel around (...) go broke before paying for day care centers (...) it's their fault, they're half to blame!". Rita pins deaths on the economic system: "As long as Brazil is capitalistic many children are going to die 'a *mingua*! When it becomes socialistic deaths will decline!".

Grinding poverty, unemployment and lack of "conditions" kills (4%): "A father feeding five, six, eight children on a minimum salary (...) that's a miracle!". Tânia's, 42, two-year-old son died because "my husband was out of work (...) we were desperate!". When he finally found work, it paid a pitiful wage. "I was in total despair (...) we couldn't find a cent (...) even a crumb!". Umbanda healer, Francisca, agonizes over the death of her only child: "He died 'a *mingua*' because we lacked food, a doctor (...) No, it isn't God's or the parents' fault, no! It's the lack of 'conditions'". Poverty is the culprit.

Exposure to "dirtiness" kills, insist mothers (2.3%). Make-shift houses, fecal waste, contaminated drinking water "invites disease to knock at

your door (...) In houses of mud and sticks, covered with cardboard boxes and plastic bags, who do you expect to visit, if not death?". Graça, 32, washed clothes in a polluted stream when her son accidentally "drank some ugly water". Within 24-hours, "he died from the bath in the river!".

Violence, accidents and lack of "humanity" (solidarity) is fatal (1.7%). Elenice, 23, says "the violent world (...) the lack of people's humanity (...) to look after one another" killed her son. Afraid of wandering gangs and stray bullets, she hides indoors with her kids: "I don't seek help anymore for my kids". Eight months pregnant, Valdira, 35, slipped, "hitting my big belly with the heavy zinc pail I was carrying on my head (...) filled with water!". The next day, she delivered at home "with only me and God present!". The baby cried meekly and died.

Mothers accuse hunger, "fluffy" food without substance (vitamins, nutrients), and "weakness" (chronic malnutrition) for death (4.6%). Mothers "trick the belly into thinking it has food", feeding cheap (rice, beans, manioc), "fluffy" (icing-filled cookies, cheese puffs) and leftover food. "Escaping hunger is a miracle (...) It's Jesus's divine force feeding these kids (...) food, they don't have!". Elenice, 43, abandoned with 13 children, struggles to "make ends meet (...) with nowhere to drop dead!". Lucas, her youngest, "became really ill from a cold (...) only skin and bones!" [author's emphasis]. There was no food. "You go searching for something (...) cereal, milk (...) but there's nothing!". Scavenged leftovers lacked "substance" provoking vitamin A deficiency, night blindness and muscular weakness. "His vision sickened (...) by 6:00 pm he couldn't walk without knocking into walls!". When she found work, Lucas improved: "Just get my hands on some food, and hunger is frightened-off! (...) Just eating one time a day, he was walking!". Even so, "the poor little thing died".

A "hassled and hurried life" (*vida aperrriada*) is deadly (3.5%). An overload of chores – hauling water, washing clothes, cutting firewood – wears-down housewives, robbing them of precious time and energy to care for sick children. "I drag a heavy cross", says Edna, 54, devoted Catholic mother of five. Her husband's alcoholism made life *aperrriada*: "I work hard all day in the fields, far from home, hoeing and planting to buy bread for my kids (...) He arrives home stinking drunk!". Lacking education or skills, single heads-of-households become "slaves" in the exploitative, migrant-wage labor market of Fortaleza. Maria, a live-in nanny, toils long hours to earn a "starvation salary" feeding and bathing upper-class infants –not her own. She races out-the-door to catch the 4:00am bus to work, yelling instructions

to her 11-year-old daughter, Rosinha: "Leave him in the hammock (...) take the cereal off the stove!". Despite Maria's precautions, a neighbor witnessed the teenage girl "dying of hunger", sucking the baby's bottle of cereal as he slept. Five days later, he died.

Wives' fear and submission to male partners' authority, threats, and violence is fatal (1.2%). Men make unilateral decisions about children's hospitalization in Fortaleza. "It's 'machismo' (...) the man of the house has the last word (...) he decides everything!" says Dorilene, 38, after her husband, Francisco, left her – and seven kids – for "his other family". Their baby sickened with "black spots on his little hands". The doctor ordered Dorilene to hospitalize him; Francisco refused: "He wouldn't hear of it, no way!". When she explained "it was that dangerous disease, syphilis (...) passing from husband to wife", he violently accused her of adultery. Despite vehemently denying extra-martial sex, "He made a huge scandal (...) threatening to kill me!". Terrified, Dorilene obeyed his decision. She rocked her boy in his hammock until death "arrived".

A "troubled" pregnancy kills newborns (8%). Fátima lost her one-month-old daughter from "swollenness" (*pre-eclampsia*): "My deliveries are dangerous (...) My legs swell-up (...) from the waist down". The baby was born "in a hurry (...) cried meekly and died". Emotional problems, physical aggressions or disease "impress" upon the baby "still inside the belly". Newborns "already come into the world weak, tiny (...) without strength to defend itself". Seven month pregnant, Benita – mother of ten – suffered a severe emotional shock when her husband accidentally died: "The shock was too big (...) my entire body was trembling inside (...) messing-up the fetus!". Days later, she delivered a premature baby, who died immediately. Jandeira's husband's mental illness "killed" one of her unborn twins: "My husband's head is sick (...) during attacks, he becomes very strange! (...) It attacked the [unborn] baby who died from so much upset!".

Breaking post-partum taboos upsets mothers' delicate body balance and "dries-up" breastmilk, causing death (2.9%). Zilma's breastmilk overflowed "dripping on the ground" after birth. Threatened of being fired from her job as a live-in maid, she hastily weaned her newborn, "gave" it to her cousin, and returned to work in Fortaleza. The baby "didn't take to powered milk", became sick with diarrhea and died "only skin and bones". Hospital norms kept Lourdes, 43, from sleeping with her newborn, forcing her to wean her sick baby. "He was such a big, strong boy! They hospitalized him with just that little bit of food. But it's not strong like mothers' milk, no!

He just withered away!". After 15 days, he died on the pediatric ward.

Common popular illnesses are liable for death (13.8%). A sudden fright (*susto*) provoked a profuse, green, foul-smelling diarrhea, killing Raimunda's son: "A devilish dog barked and frightened the baby (...) three days later he was under the ground!". "Evil eye" attacked and killed Juraci's baby when a stranger admired him: "Oh, what a beautiful boy (...) so chubby and cute (...) He couldn't be yours (...) his little bottom is so fat!". His stomach cramped, "diarrhea fell like a waterfall from heaven" and he died. Umbanda priestess, Francisca's son died "in 24 hours" from "the deadly vulture-hex sent to kill my brother (...) but grabbing my boy instead". Not even Dona Chaga's powerful prayers saved her only son from *doença de criança*: "Arriving to kill, nobody – except God – saves that child!". She still insists: "There are mothers who are crazy for their kids (...) she will spend, spend, spend (...) to save that child's life!".

Common, infectious diseases that "attack the innocent's body" are a leading cause of death (24.1%). Weakened by malnutrition, virulent biologic agents attack and quickly kill infants from diarrhea, pneumonia, whooping cough, measles, meningitis, tetanus, etc. Diseases "in the blood" (hereditary) are fatal. Tânia's seven babies were born to die: "All my babies died (...) it [disease] comes in the blood!".

"Untrustworthy" public health services provoke death (1.7%). Although six of Raimunda's 17 children died, she opted for the traditional healers' care over physicians'; she confides in the quality of religious healing: "I only go to the healer (...) She asks what's wrong, prays on us (...) cures. I have faith in God, in her prayers (...) She's my doctor!". Admitting that doctors "know a lot", their ways are unfamiliar: "I never liked doctors one bit (...) You have to tell them everything that's wrong!". Raimunda consciously decides to seek popular medicine: "So, I ask myself, 'Oh, my God (...) show me the path I have to take (...) the doctor's or healer's? (...) I go to the healer and get well".

Blocked access to emergency medical services provokes death (5.7%). Midwife, Dona Chiquinha is famous for her "experienced hands". Yet, her newborn died at birth for want of medical assistance: "We lived far from doctors. Not even a healer lived nearby (...) my baby ended-up dying". Lourdes' infant died on the way to the hospital: "The baby was breathing hard (...) and no bus to Fortaleza passed by! It's the most difficult thing in world! (...) When I finally sat down, he had his first attack. Before you could blink an eye, he was dead in my arms!". For this devoted Catholic mother of 12 children (one adopted) – just 12 days shy of delivery – the emergency room staffs' recep-

tion was downright cruel: "The nurse jerked my son from my arms and sent him [courtesy of the State] to the Medical-Legal Institute to discover what killed him!". Rita, eight months pregnant, "almost died from hunger dragging my huge belly all the way to Fortaleza" to save her 10-month-old daughter's life. "My heavy belly was hurting so much and the cars just kept whizzing by. My God, I kept thinking to myself, the distance is so far on foot!". Rita's husband quit work and moved to Fortaleza, visiting his hospitalized daughter every night. He cuddled the tiny girl in his muscular arms – feeding her a warm bottle of milk – "until death stole her away!".

The failure of physicians to diagnose the fatal problem kills (4%). Distraught parents take doctor's comments that he/she has "no clue what's wrong", to mean "disinterest" in the child. Raising two adopted kids, Terezinha became outraged when pediatricians failed to discover the disease killing her (biological) baby: "Night and day, I lived at the doctor's office (...) he only said: 'I don't know what she has!' (...) My God, can you believe that?". A gloomy prognosis is tantamount to death. When doctors told Edna her son's "only chance of surviving is surgery" she lost all hope. "It's written on the walls! (...) If he pulls through the night (...) he won't see daylight!". No sense in prolonging the agony, she checked him out – against medical advise: "If he's going to die (...) then let it be under my control ('no meu poder') at home – embraced by love!".

"Poor care", "abuses" and "taunting" (*judiação*) of seriously-ill children by hospital staff caused the most revolting deaths (9.8%). When Claudenir, 33, entered the Intensive Care Unit, her one-year-old daughter, Natália, "was dead (...) with doctors hovering over her (...) I had a fit, bawled them all out (...) ordered them to get away from her! Because, when she was sick (...) I called them and not a single one helped me! Now that she's dead, they come running to examine her (...) saying she died of a bad heart. 'You're so stupid! I told you that! (...) so why did you operate on her lung?' I screamed. I blamed the doctors right away (...) they killed my daughter because they wanted to kill her!". Sixteen-year-old Claudia's twin girls died of fetal erythroblastosis because the doctor failed to detect RH blood factor incompatibility during pre-natal exams: "My blood is negative and my husband's is positive (...) the girls were twins with just one placenta (...) one had my blood the other my husband's. One died right after it was born, the other the next day". Claudia pardons the physician, admitting medical error: "The doctor was young and inexperienced. He even asked for my forgiveness because he was to blame for my girls' deaths". An obstetrician "mutilated" 28-

year-old Francineide's baby with forceps during delivery: "He squeezed them too tight and killed my baby (...) her soft little skull sunk-down and her foot broke-off". Francisca's eight-month-old daughter with acute anemia died from a nurse's "brutal" needle insertion while transfusing blood: "The nurse 'taunted' with her, trying to insert the needle. Unable to find her vein, she stabbed her head, her feet (...) stabbing, stabbing, stabbing (...) until my baby turned purple!". She laments not taking her home: "If she'd been in my hands, not in the hands of strangers, she wouldn't have died!". Maria's night duty nurse at the Maternity Hospital threatened to steal her newborn: "Woman, you don't have 'conditions' to raise her, give her to me! (...) One of these days, I'll carry your daughter off!". When the nurse "bought a pacifier and fastened a gold bracelet on her wrist", Maria panicked. "You could feel it in the air (...) the nurse was going to steal my daughter behind my back!". Maria had no choice: "I grabbed my daughter and left!". Weeks later, she interned her – in a different hospital – to die.

A lack of medication and the side-effects of drug killed others (2.7%). Medicines are in short supply at public clinics: "Even taking the prescription to the health post (...) it takes six months to fill!". The illegal sale of free, government-distributed drugs drains limited supplies. Few can purchase medicine at drug stores: "Fathers with five children, without a job, have no way to buy medicines!". Chiquinha's son died wanting pills: "My husband searched high and low (...) but no medicine worth anything appeared". Drugs can "damage frail organisms". A politician gave Lúcia, illiterate, free pills in exchange for her vote: "I gave the pills to my daughter exactly as he said. But, in my mind, she got worse! By bedtime she was totally limp (...) with the world's biggest waterfall of diarrhea!". Before sunrise, Lucia's daughter died.

Releasing children from the hospital – still sick – kills (4%). Fatima's daughter was born premature, only eight months after conception. Fragile and low-weight, the pediatrician released her after two days, despite Fatima's protests: "She's so very tiny and difficult to raise!". Forty days later, she died. It took Nazaré four frustrated attempts to hospitalize her gravely-ill daughter. After 17 days receiving "blood transfusions for anemia", she was released. "At home, she worsened. I took her back (...) but doctors refused to hospitalize again (...) saying it was just a little pneumonia (...) She really sickened and died".

Divine destiny fates death's hour (1.2%). Of 12 children, Raimunda lost seven "born with a signal (...) they wouldn't go forward". She "fought" until exhausted, "surrendering" them unto The Almighty Father; he alone decides if "they'll die

on that day (...) be freed of suffering". Neighbors say her youngest died of evil eye. But Raimunda resigns herself: "When a person must die, it dies. Death only wants an excuse!".

Discussion: "maternal selective neglect" in perspective

All 45 bereaved *Cearanese* mothers blamed someone or something for their child's death. No informant held liable maternal "selective neglect", "indifference", "detachment", "underinvestment", or "ethnoeugenic neglect", as Scheper-Hughes^{9,10,12,17} interprets. Greiving mothers attribute the bulk (> 60%) of fatalities to childhood diseases (popular and biomedical), endemic in Northeast Brazil²⁰, and to "poor" quality, even "abusive", care by hospital staff – not by the mother. Incisively, mothers pinpoint a litany of death risk factors "that really matter"⁵ in poor Brazilian communities. Most are structural aggressions which grate the mother's sense of human decency. Even so, poor women have little, or no, power to change them.

Brazilian researchers corroborate my results. Of 395 bereaved mothers in Belo Horizonte, Minas Gerais State; Hadad et al.²¹ found 46% attributed deaths to inadequacies in the public hospital system; 27% blamed improper treatment by health professionals. Goulart et al.'s²² qualitative study of deaths between 1996 and 1999 in the same city, describes similar factors. In Ceará, Bezerra Filho et al.²³ identified pre-natal, birth, and postpartum care and income distribution as decisive factors for first-month survival; immunization, basic sanitation, education, economic status are possible determinants of post-neonatal death. For Calvasina et al.²⁴ popular "birth weaknesses" pre-dispose the child to death before birth and mothers' nurturing. Nations & Gomes²⁵ reveal that patients severely criticize health professionals' dehumanizing conduct in a Fortaleza public hospital.

Incredulously, Scheper-Hughes'⁹ published data on mother-reported causes of death in children < 5 years corroborates key finding of this study. The majority of deaths – 175 of 251 (69.7%) – were "naturalistic", caused by gastroenteritis and other infections. Only sixty-four (25.5%) are "personalistic" due to "human agency", with their "locus of responsibility" falling on people – on mothers – and their deleterious health beliefs and practices. Of these, only 36 (14.3%) are caused by *doença da criança*, the epitome of ethnoeugenic selective neglect⁹ (pp. 540-1). Despite its low frequency, Scheper-Hughes asserts that selective neglect is "...widespread among the poorer popu-

lations of Ladeiras but 'invisible' (...) to outsiders', even those who "come into frequent contact with severely neglected babies and young children" ⁹ (p. 295). Yet, even child abuse experts recognize that "negligence caused entirely by poverty, is not considered" ²⁶ (p. 10). So what is going on here? Why the huge fracas over "maternal selective neglect", if it is responsible – according to her calculations – for < 15% of all deaths? Is it "invisible" or rare? She claims that "within the shantytown child death 'a mingua' (accompanied by maternal indifference and neglect) is understood as an appropriate maternal response to a deficiency in the child" ⁹ (p. 295) and that "the women themselves accepted at least partial responsibility for the deaths of those babies..." ⁹ (p. 540). This is pure nonsense. Factory-worker, Rita, told us that corrupt politicians' contempt for the poor and capitalism killed her son *a mingua*. Umbanda priestess, Francisca, insists it is *not* God's or the parents' fault a child dies *a mingua*; the lack of food and of a doctor killed her only son. The dictionary definition of *a mingua* is "for want of" without connotations of willful action or abandonment in Scheper-Hughes's ^{9,10} translations. In Ceará, dying *a mingua* means a gradual death without sufficient *medical* attention: "Poor people can't get to doctors (...) so they die *a mingua* in a hammock. If they were rich, they would die in a bed! But it doesn't mean there is no one around or nobody cares about the baby. It means only that there is no doctor there, because they are poor" ¹³ (p. 193).

Even her characterization of *doença de criança* is dangerously inaccurate. Actually, it attacks up to the age of seven – when the child's fontanel "completely closes" ²⁷ – throwing doubts on Scheper-Hughes' thesis that it is related to maternal delay in bonding with small infants. It is "ugly" not because of some evilness but because it is a virulent, merciless killer ^{13,27}. The words "contagious" and "infectious" are used to describe *doença de criança*. Special measures must be taken "to protect other children from it – the dead child's clothes, hammock, and bottles must be destroyed. 'You can't even get close', said one woman, 'to where the baby died'" ¹³ (p. 180). Mothers and healers treat it with beef-bone marrow, breast-milk and dried umbilical cord tea ²⁷. Like fatal popular illnesses *foonda* and *heendu* in Mali, West Africa ³, mothers are not blamed for deaths since older women, healers, and relatives confirm the diagnosis.

Whence "maternal selective neglect"? What evidence base supports this hypothesis? Even Scheper-Hughes admits that: "...favela mothers interviewed were all too keenly aware that the primary cause of infant and childhood mortality was gastroenteric and other infectious diseases..."; that

babies die because "we are poor (...) hungry (...) the water we drink is filthy with germs (...) worthless medical care..."; that infants need "good food, proper nutrition, and milk" to survive ⁹ (p. 539). Why, then, downplay these deadly, *emically*-defined determinants? "I soon became bored with its [mothers' explanations] *concreteness*", Scheper-Hughes justifies ⁹ (p. 539). Since when is the quotidian world of lay rationality too hackneyed to excite the anthropological imagination? Are ethnoetiologies a mere second-rate explanation for experienced loss? With what moral authority can maternal agency be held liable for avoidable infant death – if it is glaringly absent from bereaved mothers' discourse? Although "bored" by the "concreteness" of her informants' explanations, boring or not, they are true. It is in fact malnutrition and poor hygiene which lead to the infections which kill most poor Brazilian children ²⁰. It is neither necessary nor sufficient to postulate maternal neglect – "selective", "benign", "passive", "masked" or otherwise – to explain high infant morbidity and mortality. Yes, *Dona Raimunda*, "death only wants an excuse" – but *not* maternal or ethnoeugenic neglect.

The competence with which Brazilian mothers care for their desperately ill infants – in such difficult conditions – is impressive. Monte et al. ²⁸ confirms that "caring mothers" (*mães cuidadoras*) – a commonly-recognized *emic* category for zealous mothers – identify harmful feeding practices and create low-cost recipes with foods that are available. During a feeding trial, 100% of *mães cuidadoras* initiated introduced practices; and more than 50% continued throughout the month-long trial ²⁸. After being empowered as "alert, capable and wise" women, 73% of *mães cuidadoras* in Victoria, Espírito Santo State, helped children with low stature, chronic and severe malnutrition to recover – *without* food supplements ²⁹. Pacatuba's mothers and traditional healers correctly prepared and administered oral rehydration solution, saving infants' lives at home ^{30,31}.

The interpretive violence of "maternal selective neglect"

"Interpretive violence" in ethnographic analysis, argues Bibeau & Corin ¹⁹, occurs when anthropologists privilege cognitive elements of a culture, ignoring its organization and social dynamics and structural impediments. When Scheper-Hughes ^{9,10} pinpoints rare (< 15%) "personalistic" diseases and "human" agents – "favela mothers" ⁹ – as responsible for deaths and then blows their "childhood-pathogen" status out of proportion, it is interpretive vio-

lence. When she becomes “bored” with mothers’ heart-felt explanations of numbing loss, it is interpretive violence. When she downplays “concrete” social determinants of mortality, conjuring up her own psychologically-driven rational (too reminiscent of Social Darwinism³², for my liking), it is interpretive violence. Anthropologists, at least, will recall Foster’s¹⁵ analogous argument of the fatalistic “Image of Limited Good” miring Mexican peasants in the muck of poverty – that was vociferously rebutted¹⁶ in the 1960s. Purely cognitive interpretations of human behavior are criticized today, giving way to an analysis of structural violence³³. In Brazil, too, social determinants of disease are gaining explanatory ground³⁴.

We have read Scheper-Hughes’¹⁷ eloquent prose about “everyday violence” in Brazil – of mothers’ muddled minds and tearless indifference. But, what of the interpretive violence of perpetuating a mother-blame myth^{11,13}? And what of the global epidemic of “insufficient mothering” and “parental incompetence” that spreads stigma – well beyond Ladeiras, Brazil? In Punjab, India³⁵, I am horrified to hear, “parental incompetence” has surfaced: “*Incompetent parents take poorer care of their children, are slower to recognize and respond effectively to their needs, and consequently experience child loss*” reports Das Gupta³⁵ (p. 458). Enough is enough.

Besides praise, Scheper-Hughes’ research has provoked a rash of commentaries^{36,37} and poignant criticisms^{11,13}. To believe wholeheartedly that poor mothers witness baby death – “without weeping” – may expurgate our feelings of co-responsibility for this human tragedy. It does little, or nothing, to confront “lived” determinants of mortality in Northeast Brazil – narrated by *Cearnense* mothers – in an authentic, heartfelt and outraged voice.

Conclusion

Poverty-stricken mothers in Northeast Brazil have been catapulted from near oblivion to academic stardom. Their behavior in, and reaction to, infant death is the subject of raging international debate. That two, divergent, ethnographic interpretations of Brazilian women’s lives and losses are written – in similar periods and cultural regions – begs comparison. In ethnographic history, it is rare to find two studies that were more or less contemporaneous, addressed the same topic and occurred in proximate locations. Without epidemiology’s rigorous control groups, ethnographic data interpretation “*is essentially contestable*” as Geertz¹³ (p. 29) says. Data verification is anchored in the more ephemeral, dialectic processes of “sustaining a discussion” and “refining the debate”.

Here I have focused on one issue – the role of maternal agency in infant death – before entering into the minutiae. Scrutinizing the ethnographic evidence base – and researchers’ subjective, theoretical and methodological biases – is necessary to judge the scientific merits of interpretive accounts. Proving hypotheses to be false is essential for creating robust anthropological theory. Brazilian anthropologists, and others, are urged to tackle the difficult questions that I have raised about poverty, maternal thinking and infant death. Critical inquiries in a variety of geographic regions and among diverse ethnic groups, social classes and religious sects in Brazil will help to refine this debate. The challenge is to validate, or refute, the explanatory power of “maternal selective neglect” as a relevant – or, indeed, morally decent – determinant of infant mortality in Brazil.

Resumo

Investiga a etnoetologia de óbitos infantis evitáveis na óptica da mãe em luto no Nordeste brasileiro. Refina o debate antropológico sobre a “negligência materna seletiva” como relevante explicação de alta mortalidade infantil. Trata-se de uma análise crítica de dados preexistentes. Entre 2003-2006, foram resgatadas 316 entrevistas etnográficas coletadas pela autora durante 1979-1989, em seis comunidades no Ceará, Brasil. Identificaram-se 45 narrativas de mães sobre a doença fatal e morte de 56 filhos < 5 anos para aprofundamento. Apesar da baixa renda e escolaridade, as mães construíram explicações próprias para a morte precoce. Causas maiores são doenças infecto-contagiosas (37,9%) e cuidados desumanizados do profissional de saúde (24,1%). Nenhuma mãe acusa o descuido, desapego ou negligência materna. Nesse contexto de pobreza, argumenta-se que se existe “desprezo” é do sistema econômico-político e social injusto e da prática da saúde pública desumana que violentam os direitos da mulher-cidadã. Caracterizar essa mãe em luto como “negligente”, ou, pior, cúmplice na morte do filho, é uma violência interpretativa que injustamente culpabiliza e desmoraliza a mãe-cuidadora nordestina.

Mortalidade Infantil; Comportamento Materno; Maus-Tratos Infantis

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