

Theorizing modernity conspiratorially:

Science, scale, and the political economy of public discourse in explanations of a cholera epidemic

ABSTRACT

When some five hundred people in eastern Venezuela died from cholera in 1992–93, officials responded by racializing the dead as “indigenous people” and suggesting that “their culture” was to blame. Stories that circulated in affected communities talked back to official accounts, alleging that the state, global capitalism, and international politics were complicit in a genocidal plot. It is easy to attribute such conspiracy theories to differences of culture and epistemology. I argue, rather, that how political economies position different players in the processes through which public discourses circulate, excluding some communities from access to authoritative sources of information and denying them means of transforming their narratives into public discourse, provides a more fruitful line of analysis. In this article I use—and talk back to—research on science studies, globalization, and public discourse to think about how conspiracy theories can open up new ways for anthropologists to critically engage the contemporary politics of exclusion and help us all find strategies for survival. [*race, conspiracy theories, narrative, health, globalization, indigenous peoples, Latin America*]

for Feliciano

Yesterday afternoon my wife, Clara Mantini-Briggs, and I stopped by the supermarket on our way home to buy provisions for a birthday party I was to host for her that night after a meeting of the small foundation we run. The temperature was over 100 degrees as we arrived at the wrought-iron entrance to the supermarket–bakery run by a local Portuguese immigrant family, the most successful entrepreneurs in Tucupita, Delta Amacuro, Venezuela.

Our attention was arrested by several bodies out of place, a woman surrounded by three children. The woman’s bright orange, flower-print dress and her location, seated on the cement floor of the passageway between two businesses, seemed to place her in the local racial economy as an *indígena*, “indigenous person,” a category that is commonly contrasted with “Venezuelan,” *criollo* (“Creole,” meaning “nonindigenous”), the “national society,” “rational,” and “civilized.” The sight of *indígena* women with infants by their sides became commonplace after hundreds left the rain forest in the wake of a cholera epidemic that killed some five hundred people in the area in 1992–93. These refugees hoped to secure their constitutional rights to health care and economic opportunity. But begging, collecting aluminum cans to sell, and (for men) the occasional odd job constitute the only work available to them, and death seems to be just as omnipresent as it was in the rain forest.

Two aspects seemed to dis-locate the four people. First, they were in the middle of the passageway, whereas *indígena* women generally beg at the entrances to businesses and other public sites. Second, the baby, some six to eight months old, was severely dehydrated. His tearless eyes lay sunken in their sockets, his tongue was dry and swollen, and his cry was hoarse

and barely audible. With only a rag placed around his hips, it was easy to see that he was seriously underweight, with tiny arms extending from his washboard ribs. Even I, a “fake doctor,” an anthropologist, could tell that death was not far away as I approached with the “real doctor,” Clara, a Venezuelan public health physician, herself of indigenous descent. Just to the woman’s right, a son, some two to three years old, stood with his face to the wall, like a statue in storage or a child pretending to be invisible. A girl of about nine or ten stood beside Clara and me in old, tattered jeans and a deteriorating T-shirt, alert and engaged.

I asked in Warao, the language spoken by most people classified as *indígenas* in the delta, what was wrong. The woman, whose name we learned was María Pérez, replied in Spanish that the child had been suffering from diarrhea but was now recovering. Suggesting that the baby was seriously ill, I asked if she had taken him to see a doctor. “We went to the hospital, twice, and the doctor told me to give him some vitamins,” Pérez said as she held up a bottle. We seemed to be locked in a Bakhtinian dance, in which I, a white, middle-class North American and long-time resident of Tucupita and the delta, spoke Warao, and the woman responded in Spanish sentences that seemed to pop like soap bubbles as soon as they left her tongue, creating traces of meaning but leaving the communicative gaps that separated us largely intact. Clara fed me lines to translate, attempting to elicit diagnostically crucial information. Pérez began to shift into Warao, bringing us closer to what felt like understanding. Still, it seemed unclear whether hospital physicians had failed to respond to the seriousness of the situation, whether Pérez had not understood the words they had uttered in a medical register of Spanish, or whether some other scenario altogether had led to the present situation. Pérez gave the child a breast to stop its crying, then withdrew it when the child was comforted, only to repeat the process with the other breast.

Another daily dilemma in Tucupita. Our fledgling organization, the Fundación para las Investigaciones Aplicadas, Orinoco (Foundation for Applied Research, Orinoco), seeks to improve health and other conditions for underserved populations in the region. We had to get home to receive our fellow organization

members for the meeting. But was the child’s life not a more pressing medical issue than the items listed on the agenda? We could leave the other members waiting in front of our house, but it was not clear that sticking around the supermarket would reveal a strategy for saving the child’s life. Pérez was much closer to the medical facilities that she had sought in leaving the rain forest, but medical justice—and saving the life of her child—seemed to be just as far away.

Just at that moment, another woman entered the passageway between the bakery and supermarket. Her new, tightly fitting jeans, stylish blouse cut to reveal her bellybutton, and carefully groomed hair placed her in the local racial economy as a *criolla*. She was pushing a reluctant girl of about three years old toward Pérez, laughing all the while and taunting the child, “I’m going to leave you with her, I’m going to leave you with her!” The child, with fair skin and light brown hair, dressed in new jeans, a pretty pink blouse, and bright white sandals, struggled to retreat into the bakery, crying out, “No, no, no, no!” Daily acts of racism can construct a mother with a critically ill child as a monster, capable of filling one member of the racially dominant sector with terror and another with mirth. The scene went by quickly as the *criolla* mother pulled her daughter beyond us and into the supermarket, leaving us just as dumbfounded as the medical dilemma that was unfolding simultaneously. Clara cautioned Pérez against using the baby bottle that she was about to give the child, extolling the virtues of breast milk and pointing out that the smell of the bottle indicated that it was not clean. I gave the woman some money to help her get back to the hospital. We walked away, wondering how any program we inaugurated could measure up to the challenges that we had just, unsuccessfully, confronted. For us, yet another layer had been added to the meaning of racism, health, and daily life in Delta Amacuro.

This scene evokes the ghosts that lurk just beyond the fringes of the small city of Tucupita. Some 24,000 residents of the delta of the Orinoco River are classified as *indígenas*, specifically as members of the “Warao indigenous ethnic group.”¹ A recent survey of several communities in this region found that 36 percent of children die in the first year of life (Servicio de Apoyo Local 1998). Some 60

percent of adults test positive for tuberculosis.² For most of the places in which you, my readers, live, an infant mortality rate of 36—that is, 36 deaths out of 1,000 live-born children—would be scandalous. But the daily struggle of María Pérez to keep her children alive and the deaths of so many infants seldom provoke public comment, let alone scandal.

The same process of erasure that renders these deaths invisible also thwarts our awareness of the profound effects of infant deaths on the lives of parents. Clara and I have interviewed many parents who have had eight or ten children and who comment bitterly that only one or two of them are still alive. The deaths add layer on layer of trauma, feelings of loss that undermine people's sense of meaning and agency. Following Avery Gordon (1997), one can say that dead become ghosts that are only visible at the boundary of the nation-state and its modern citizens. Their invisibility helps to define the categories, borders, and relations of established social orders, reifying complex and contested networks of bodies and meanings as coherent systems. By their lingering presence, these ghosts hold the potential to reveal the constructed, arbitrary, and problematic character of both nation and state.

During conversations with parents and participation in many funerals, I often wondered if I would be able to survive the loss of even a single child. Life in "the field," of course, is a textually mediated experience. As I watched so many children die and heard their parents talk and sing about their suffering, I often thought about Renato Rosaldo's (1989) powerful account of his own responses to the death of his wife, Michelle Rosaldo. Like many people, I can still remember who told me about her death and my sense of loss for an esteemed colleague—and how I pondered its impact on Renato and their children. (Forgive me for breaking academic convention in referring to him by his first name. It is not just that I know Renato, but I also have trouble constructing him simply as an author here.) Renato writes that he never grasped what Ilongot men meant when they spoke of how the rage following the death of a loved one moved them to kill and decapitate another human being. He suggested that, not having felt so great a loss himself, he could not understand their words—until Michelle's death. The rage that he experienced then thrust him into a subject position that permitted him to grasp the force behind the Ilongots' words. As I was surrounded by death in the delta, I knew that I occupied exactly the position that Renato described—a fieldworker who lacked the human experiences that formed the focus of the cultural forms that he or she investigated.

Both of the scenes I have described, a woman sitting just outside a bakery with a dying child and rain forest communities in which so many babies die, may seem

remote to many of you. But it is part of a world in which you and I are intimately involved. The neoliberal policies and practices of multilateral lending institutions, the governments of wealthy countries, and transnational corporations have greatly increased the gap between the rich and the poor, both between and within nation-states. From 1960 to 1991 the portion of the world's wealth enjoyed by the poorest 20 percent of its population dropped from 2.3 to 1.4 percent. Although only one-fifth of the world's population lived in countries with the highest incomes, these people accounted for 86 percent of expenditures for private consumption worldwide; the poorest 20 percent accounted for only 1.3 percent (United Nations Development Programme 1998). As Jim Yong Kim et al. (2000), Vicente Navarro (1998), Richard Wilkinson (1996), and others suggest, social inequality has serious health implications. The "reemergence" of such classic killers as malaria, dengue, and tuberculosis and the erosion of social security systems and sanitary infrastructures in Latin America (see Armada et al. 2001) demand reflection on the part of people who live in the countries in which global economic policies are generated. Paul Farmer (1992, 1999, 2003), Veena Das (1995), Nancy Scheper-Hughes (1992), and other medical anthropologists have powerfully revealed the political economy that renders the lives of most people on the planet expendable, just as historians have pointed to the way that connecting race and a perceived lack of medical modernity—as a sign of a lack of civilization—constituted a key part of many colonial projects (see, e.g., Anderson 2003; Arnold 1993; Hunt 1999). My goal in this article is to examine some of the ways that this erasure takes place and how people try to restore their own visibility.

One of the "reemerging infectious diseases" is cholera. Absent from Latin America for nearly a century, an epidemic began in Peru in January of 1991 and affected nearly all of the countries in the region. Cholera is the classic disease of social inequality. It is symbolically associated with dirt, ignorance, premodernity, and the racial Other. Generally transmitted by contaminated water and food, it is easily prevented by adequate sanitary infrastructures and is treated by simple medical techniques, just the sort of services that suffered from structural adjustment in the 1980s. And it is scary. Cholera can kill a healthy adult in as few as eight hours after the onset of symptoms, and the appearance—and smell—of the cholera patient are not pretty. According to a survey of delta communities that Clara and I conducted in 1994–95, some five hundred people died in the Orinoco Delta from cholera in 1992 and 1993.³ But the World Health Organization (WHO) was only told about 13 of those deaths, a form of discursive erasure that prevented an international outcry or visits from WHO officials.

Techniques of erasure are varied. Gated communities try to shut poverty and violence outside. But in most urban areas, the homeless are pressed into spaces in which more fortunate residents live or work. In such spaces a more intimate politics of invisibility is needed, guided by practices of looking and not seeing, of making such sights seem unremarkable. Or even, as the bakery scene suggests, using such sights as a means of getting a laugh. Epidemiology provides powerful techniques of erasure, including means of turning people into categories and numbers and then providing states with control over the production, circulation, and publication of these “data.”⁴ In previous work, Clara and I focused on how state officials blame the deaths of *indígenas* in the delta, during the epidemic and in “normal” times, on the purported failure of mothers to save their family members—or even to try (see Briggs with Mantini-Briggs 2003). These accounts turn the effects of a triple inequality of health (Breilh 2003)—of gender, race, and class—into an immodest claim of causality (Farmer 1999) that purports to explain such deaths. In claiming that the intractability of *indígena* mothers is demonstrated by their purported inability to mourn the deaths of their children, state officials demonstrated their own ignorance of daily life in delta communities. When even the smallest infant dies, female relatives surround the corpse and collectively compose ritual laments that express not only sorrow but also anger directed at anyone deemed responsible for prompting the death (Briggs 1992, 1993).

During the epidemic and in its aftermath, patients, community members, and activists talked back to these accusatory images, constructing a wide range of alternative explanations. Nevertheless, few of the explanations ever made it into public discourse, into newspapers, radio and television broadcasts, reports, or planning documents. This article identifies three practices of erasure that facilitated their exclusion. I focus on a sort of slippage or wiggle room that exists between seemingly contradictory means of constructing modern subjects. One practice exploits the distinction between science and society, between natural objects and social subjects, focusing in particular on people who do not seem to know the difference. The second practice emerges from processes that seem to produce global versus local subjects, people who live in worlds based on a global vision and those who do not seem to be able to see beyond their own noses. The third practice has to do with a contradiction in how public discourses are produced and circulate—and how people get interpellated in this process. Each of these practices can be exploited in creating ghosts and then rendering them invisible. Some of the strategies that critique and challenge these practices and attempt to render the ghosts visible are often referred to as “conspiracy theories.” My goal is not to characterize conspiracy theories as “paranoid” (Hofstadter 1967) or as quintessential embodiments of Cold War logics or post-

modern sensibilities (Marcus 1999), much less to celebrate them as discursive acts of popular resistance. I am, rather, interested in the insights that a set of conspiratorial responses to an outrageous situation can provide into developing critiques of “scattered hegemonies” (Grewal and Kaplan 2002).

My focus goes back to Delta Amacuro, to the rain forest area and to adjacent urban spaces, not to make conspiracy theories strange but to reflect on features that such theories hold in common with words spoken and written in other places. Official accounts represent a situation that is so depressing and dramatic and the techniques they use in suppressing outrage and making death seem normal are so productive that it can be as edifying as it is alarming to see how little overt discursive work is needed to turn a medical nightmare fostered by racialized medical inequalities into something that seems natural and interpretable. I am interested in what seem to be rather exuberant and sometimes even outlandish attempts to disrupt the normative operation of this economy of erasure. In accounting for the seemingly strange character of conspiracy theories, I shift the focus away from notions of epistemological or cultural difference to think about the political-economic parameters that shape how particular accounts get placed within—or excluded from—the circulation of public discourse. I think that the implications extend far beyond epidemics, rain forests, and conspiracy theories, providing a means of seeing how discursive economies operate and how people—including anthropologists—get interpellated in the process. The stakes are high, involving how different populations are constructed by the state, what sorts of rights they enjoy, and, for many, issues of life and death.

Cholera in Delta Amacuro, Venezuela

The Orinoco Delta, a fluvial region in eastern Venezuela with an estuarial coastline, encompasses 40,200 square kilometers and has a population of about 40,000 (Oficina Central de Estadística e Informática 1993). Medical services in the area are limited, and transportation is difficult; the delta thus provided an ideal locus for a cholera epidemic. Because cholera appeared in Peru in January of 1991 and Venezuela did not report cases until late November, the country had time to prepare for the inevitable. Delta Amacuro was a cholera-free zone until August of 1992; it thus had even more time than other areas of the country to respond to directives from the Ministry of Health and Social Assistance (MSAS) to put anticholera measures in place.⁵ Unfortunately, very little was done, and very few people had even heard of the disease.

Few communities in the fluvial region received instruction on cholera or knew that treatment was required immediately. Medical supplies had not been stockpiled in

the few clinics that serve the rain forest area, and physicians were absent when anguished voices on two-way radios announced the beginning of the epidemic. In some small communities as many as a third of the adults died within the first night or two (see Briggs with Mantini-Briggs 2003). The epidemic thus compounded insecurity around issues of life and death in a region that has among the highest rates of malnutrition and infant mortality in Venezuela.

The cholera epidemic continued to exert detrimental effects on living conditions after new cases had slowed to a trickle by June of 1993. When the health refugees who left the delta drew the attention of reporters, officials reacted to the exodus by rounding up the refugees and sending them back to the delta by military transport; the cycle is still repeated frequently. Both the cholera epidemic and its diasporic aftermath prompted criticism of the regional government, including criticism by opposition politicians. Deeming the Warao to be a political liability, politicians and administrators subsequently turned an even deaf ear to conditions in the delta, responding with a mixture of disinterest and contempt to petitions presented by *indígenas* for improvements in medical services, political representation, and human rights and protesting land expropriation and environmental degradation.

Publicity that focused on the epidemic threatened the legitimacy of public health institutions in Delta Amacuro. The stigma attached to the emergence of a disease that conjures up visions of backwardness, lack of hygiene, poverty, inadequacy of health infrastructures, and state negligence led to the dismissal of the regional directors of MSAS and the Office of Indigenous Affairs. It also contributed to the replacement, by voters, of the Acción Democrática with the Movimiento al Socialismo Party in the state government in 1993. Official embarrassment was exacerbated when it became apparent that no serious efforts had been made to prepare for an epidemic.

I arrived in Delta Amacuro in November 1992. Although I was only able to stay for a few weeks, I interviewed some of the hundreds of delta residents living on the streets of Tucupita, the capital, and talked to community representatives, activists, and government officials. It was a terribly painful time for me, feeling the impact of the deaths of so many friends at once and seeing the continuing suffering of their relatives. I felt some degree of trauma for a couple of months, and I found it difficult to return to academic business as usual. In June of 1993, I met Clara, who worked for MSAS and had played a major role in attempts to halt transmission of the disease. We created a pilot program in cholera prevention for Mariusa, one of the areas heavily impacted by cholera and with the least access to health services, providing health education and establishing a nursing station. I subsequently decided that if my research on culture, communication, and healing

was to be of any value to the people with whom I had worked for years, now was the time to put it to use. I returned to Delta Amacuro in June of 1994, and Clara and I worked together for 15 months, continuing the health education program and documenting the epidemic.

At first glance, residents of the fluvial region would seem to be the definitive premodern subjects. Most live in houses with palm leaf thatching and no walls, perched on stilts above the river. The major source of transportation is the dugout canoe, and most people subsist from fishing; gathering forest products; growing swidden crops; selling hammocks, baskets, and other handicrafts; and, when available, wage labor. Warao, an indigenous South American language, predominates. Even in the few communities that boast a clinic staffed by a resident physician, a range of vernacular healers who use chanting, therapeutic touch, the ingestion of tobacco smoke, and divinatory dreams are consulted frequently (see Wilbert 1972, 1987).

One would be mistaken to posit some sort of insurmountable epistemological or informational hiatus between delta communities and those on the mainland. When people brought their relatives to clinics, nurses and physicians imparted their views of cholera and why it was spreading. Radio stations in Tucupita transmitted public health announcements. Persons who had been to town carried copies of *Notidiario*, the regional newspaper, back into the delta. Even individuals who had not listened to the radio or read the newspapers heard these narratives as they were retold countless times. Community leaders and activists also reported official accounts in the course of political organizing. Many conspiracy theory narratives that resisted official interpretations still incorporated some of the most crucial premises—especially the hybridization of medical and racial imaginaries that identified cholera with *indígenas*. And, to be sure, some people classified as *indígenas* assimilated the official narratives, extending this “geography of blame” (Farmer 1992) to their neighbors, the *really* “uncivilized” *indígenas*.

From the opening days of the epidemic, public health officials cited crabs as a key means of transmitting cholera. Given the lack of detailed epidemiological data at that point, the crab motif seems to have been an adaptation of the widespread belief that ceviche, a dish containing uncooked fish, played a key role in spreading cholera in Peru. Crabs become the rhetorical anchor for the emergence of far-ranging attempts to link cholera in the delta to the “customs” and “culture” of *indígenas*. Along the way, crabs got thoroughly culturalized. Articles that appeared in the local paper suggested that crabs lie at the heart of *indígena* kinship patterns, economics, ritual, curing, and mythology. Officials claimed that the epidemic had originated in a religious ritual named the *nowara*, in which a Warao kin group consumed “a collective banquet” of crabs and *yuruma*, a product derived from the moriche

palm. This imaginative epidemiology was not troubled by the absence of the nowara in the affected area.

The crab rhetoric offered a number of benefits to public health institutions. It located the space of cholera death far from Tucupita, in both geographic and cultural terms. Rather than a failure of public health institutions, the epidemic seemed to be the unfortunate result of the accidental ingestion of bacteria by a creature that lies at the center of a culture. Any possible responsibility for government agencies and corporations was conveniently erased. The account had an initial credibility in Tucupita in that it conformed to the sort of cultural-cum-environmental stories told about communities racialized as *indígena* that combine scientific discourses drawn from microbiology, clinical medicine, epidemiology, and anthropology. In short, it conformed closely to common practices for producing authoritative representations of *indígenas* for consumption by people who identify themselves as *criollos*.⁶

Nevertheless, delta narrators pointed out two fatal flaws in these stories. First, the Regional Health Service soon prohibited the consumption of shellfish, and the National Guard confiscated crabs and fish. The crab story was undermined by its own success, as many people stopped eating shellfish. *Notidiario* quotes the “cacique” (or *indígena* leader) Juan Zambrano as saying that “even though we have stopped eating hairy crabs, new cases of cholera have been reported” (1992b: 24). Another epidemiological difficulty is that crabs are ordinarily boiled in the delta, and cooking crabs removes the danger of infection. People who ate boiled crabs also became infected. Second, some people classified as *indígenas* and some as *criollos* challenged the way that the crab assertion combined scientific with popular racial representations. Salomón Medina, who lived in Mariusa, told me in the midst of the epidemic,

The *criollos* tell us that “the water is infecting you.” The *criollos* say that “the fish are killing you; your food, crabs, is killing you; crabs are angry at you, are hurting you, have killed you; when you eat crabs they kill you.” But we don’t believe that. . . . Another *criollo* said the same thing: “No, these Warao aren’t getting sick from eating diseased crabs. I ate crabs, I eat crabs. We *criollos* eat crabs and we haven’t died.”

The “*criollo*” to whom Medina refers may well have been Blanca Cardenas, director of the Regional Office of Indigenous Affairs. Raised in the delta and fluent in Warao, she proudly told me that she ate crabs in delta communities, even raw, during the time that MSAS had prohibited their consumption.⁷ Although Medina preserves a key premise of official narratives, the idea that stories about the epidemic are tales about racial difference, he challenges the racialization of crabs and cholera vis-à-vis a fixed racial border.

Some accounts use the language of science and biomedicine to challenge official interpretations. A young man who claims to have a degree in biology often worked in commercial fishing camps. He refers to the crab narratives as “something fictitious or something to stop up a leak.” Commenting on the international cargo ships that transport oil, steel, bauxite, and other materials through the delta, he suggests that the failure of MSAS to properly inspect vessels led to the discharge of a suspicious chemical into the water, thus producing diarrhea and death. He claims that the samples of the toxic liquid he collected from delta rivers were confiscated under orders of the Regional Health Service. Note that commercial fishermen were hurt financially by lower sales prompted by official accounts that depicted fish as cholera vectors. Thus, although the biologist’s narrative may attempt to subvert the state’s efforts to protect its political back, it serves other hegemonic interests.

The account of an activist who lives in the nearby city of San Felix insinuates that officials intentionally created the epidemic. Raised in the delta and fluent in Warao, the activist José Guevara is classified by some as *indígena*, by others as *criollo*. Guevara combines the biologist’s reference to discharge from international vessels and the government’s assertion that the causal agent was *Vibrio cholerae*: “It isn’t the case that cholera was born. Cholera was planted here by the ships that take products to the basic industries—that they detected cholera and then they were anchored on the edge of the shore, submitting them to quarantine in an area that was not appropriate for this purpose.” He accuses MSAS officials of placing boats with cholera-stricken crews just off the coast, knowing that estuarial movements would spread the infectious agent along the rivers that provide drinking water for delta communities. Guevara further draws on official narratives in suggesting that crabs became contaminated, thereby infecting residents of other parts of the delta. In this widely disseminated story, epidemiological narratives are thus recontextualized in such a way as to impeach the individuals who created them.

In the wake of a prolonged economic crisis, the Venezuelan government entered into joint use agreements in the 1990s with transnational companies for oil exploration and production in the delta. British Petroleum (BP) reopened old wells in the northwestern corner of the delta, conducted seismic tests, and drilled exploratory wells. In 1994, shortly after BP began working in the area, residents had incorporated petroleum into cholera narratives, envisioning cholera as a poison that was dumped into the rivers through oil exploration and dispersed by the explosions ignited in seismic testing. Some accounts used epidemiological images of crabs and fish as vectors, arguing that marine species had absorbed the contaminants that petroleum exploitation deposited on the river floor.

Within the racialized space of the delta, one community near the mouth of the Mariusa River is seen as most fully embodying the “uncivilized” or “irrational” character of *indígenas*. Many of the people who reside there live in moriche palm groves and do not practice horticulture or engage in wage labor. They are seen—even by those classified as Warao—as totally immersed in a “savage” world of magic and shamanism. Because Mariusa is placed at ground zero in the social space of race, it is small wonder that many of the etiological narratives located the beginning of the epidemic there. At the same time, many narratives told by delta residents imagined Mariusa as the front line of assaults on *indígenas*.

Mariusa residents have traveled for centuries across the Caribbean to the southern coast of Trinidad, a distance of some seven miles; an 18th-century mission there attempted to convert delta *indígenas*. The Warao continue to be the focus of tales of identity for many Trinidadians (see Goldwasser 1996). During the 15 years that I have visited the area, Trinidadians have come regularly to Mariusa—generally several times a week—to buy crabs. Mariusans frequently complain about the miserly sums that Trinidadians offer them in exchange for the difficult work of digging crabs out of the mud. One widely disseminated narrative claims that a strike by Mariusans prompted the epidemic. When the people refused to fill Trinidadian boats with crabs, the entrepreneurs responded: “‘Okay, fine!’ So right then they starting putting poison [in the water], for the crabs. They kept on making poison. Then the black people left. So [the Mariusans] in turn went and got crabs and ate them. . . . And that’s how the disease began.” Because many delta residents travel to the Mariusan coast in July and August to collect crabs, the disease was disseminated throughout the area. This narrative is clearly in dialogue with the official accounts, in that it targets both Mariusans and crabs in imagining the epidemic.

Although this narrative expands the *dramatis personae*, it continues to imagine the delta as the border that encompasses the cholera story. Other narratives disrupt the spatializing practices of official narratives more radically. In January and February of 1991, the United States and other “allied” nations bombed Iraq and Kuwait. As news of the war reached delta communities via copies of *Notidiario* and reports on Radio Tucupita, I was placed at the center of the conflict in the geopolitical imaginary of many delta residents. Locals described the U.S. government as *Dokomuru aidamotuma*, “Charles’s leaders.” If the United States was so centrally involved in a war, then it must have been defending its own territory against a foreign invasion. Accordingly, all persons who could fight must have taken up arms. After the conflict ended, teacher Feliciano Gómez was asked to write me a letter, “to see if you were still alive.” The missive never reached me, and, thus, I did not respond; a rumor then went around the

delta that I had died in the war. When I returned to Tucupita in November of 1992, quite a number of friends were shocked to see me, and it took some doing to convince them that I had not been killed.

News of the Gulf War was still fresh in people’s minds when the cholera epidemic began nearly a year and a half later. In 1994, Clara and I were working with Ramón Gómez, a resident of the Arawabisi area who has been affiliated with both the COPEI political party and the Regional Office of Indigenous Affairs. He had requested our assistance in freeing his niece from prison. Rather than investigate the possibility that she had been the object of unfair labor practices, rape, and medical malpractice, the authorities incarcerated the woman, who at age 15 had been working as a domestic in Tucupita, for infanticide (see Briggs and Mantini-Briggs 2000). Gómez lives in Arawabisi and also rents a room in Tucupita. After we visited the young woman in prison, Gómez and his wife came to our house to discuss the case. Gómez spontaneously related this narrative.

When the river had reached its high point [two years ago], we heard that a war was going on. It was the Americans, with Iraq. They fought and fought, and they dropped their fire into the water—that’s what we call it. In Warao we call it that, in Spanish they’re called “bombs.” They dropped them on the ground and they dropped in the water and then dropped them in the water. They have some sort of poison in them that affects the fish, the water, and the crabs. And crabs come from the sea, from the sea when their season arrives. From the time that they fought one year passed, and that water came from over there, very slowly. [The poison] dispersed in the water and came slowly. And that poison made the fish turn bad. Now you can no longer eat them or you get diarrhea. Since the crabs also live in the ocean, they also got the poison. It doesn’t kill them, but the crabs come to where the people live. When they catch fish and they eat them, they get diarrhea and vomit; and when they eat crabs the same thing happens. They get diarrhea and vomit and their soft bodies become rigid. It’s just as if they were poisoned. They get really sick.

So the Warao people think, “*Criollo* doctors say that crabs are to blame for this cholera.” But we Warao say, “Crabs don’t have cholera.” We think that the water is to blame. The people who were fighting dropped an element that made the water bad, and it spread throughout the oceans. It’s because they dropped bombs, they dropped bombs from the sky on ships. . . . What sort of disease did the bombs produce there in the water, in the ocean? A gas or a microbe that somehow infected the water and, by infecting the water, also infected the fish and infected the crabs. And so, for us Warao, this cholera didn’t come on its own.

Gómez was well aware that I am a gringo, a citizen of the country that, he asserts, dropped the bombs; I thus share in the responsibility for the epidemic. This story seems particularly intriguing to me as I write these lines, just after “my leaders” fought a second war against Iraq.⁸

A Tucupita activist, Esteban Castro, extended the Gulf War story in attacking epidemiological narratives that blamed Warao culture. The epidemic formed part of a master plan developed by government officials who wish to get rid of the Warao once and for all, thereby eliminating the major obstacle that stood in the way of *criollos* enjoying free access to the delta and its natural resources. Castro specified that the causal agent was a “superbacteria” that had been developed by the U.S. military for use in the Persian Gulf War. Venezuelan officials purportedly obtained quantities of the bacteria, which they spread at strategic points in the delta. Other narratives provided eyewitness accounts of *criollos* dumping barrels labeled “poison” into the Orinoco. The early 1990s marked an intense land struggle, as government-backed investors appropriated rights to areas used for palm heart and timber extraction, cattle ranching, and agrobusiness. Articulate *indígena* leaders presented demands for an end to land encroachment, economic exploitation, lack of political representation, and human rights abuses. With the support of national leaders of the “500 Years of Resistance” movement of 1992, unprecedented protests were held in Tucupita. Accepting the medicalization of the epidemic, social movement leaders seldom placed cholera on political agendas. But cholera narratives wove the epidemic and the political movement closely together. Because social relations were marked systematically by racism, social inequality was increasing, an antiracist movement was visibly challenging the status quo, and people started dying in a rapid and horrifying fashion from an unknown disease, the idea that “*criollos*,” corporations, the government, or all three were attempting to commit genocide seemed to make a lot of sense.

The early days of the epidemic were catastrophic for vernacular healers. When the first cases appeared, curers tried techniques commonly used to treat other diarrheal diseases—therapeutic massage, singing, and the ingestion of tobacco smoke. Patients did not respond to treatment. Healers’ hands became contaminated by diarrhea. In an area where soap is rare and people eat with their hands, many healers became infected, and as many as half died in some communities. The dreams that reveal the source of pathogens and empower curers to treat ailments did not come. When people sought help at clinics, they witnessed the miracle of rehydration therapy; after being hooked up to as many as three or four IVs, nearly unconscious patients, people who had been given up for dead, regained consciousness and were talking and sitting up within a few

hours. The authority of vernacular curers suffered a serious blow. During the initial months, curers could tell only the most fragmentary and hesitant narratives, unable to draw on specialized knowledge of invisible spirits in accounting for the facts that surrounded them.

After the epidemic subsided, many healers who had initially been stumped once again began to have the spirit dreams that infused their narratives with authority. One of the first attempts to use the language of spirits to explain the epidemic involved a dance performance in Caracas, the nation’s capital. Ramón Gómez, who told the story about cholera and the Persian Gulf War, was called to Caracas in June of 1992 to perform with his troupe in an “Intercultural Encounter” with the Venezuelan armed forces.⁹ The event formed part of the celebration of both the fifty-fifth anniversary of the National Guard and the Columbian quinqucentennial. The National Guard had been criticized for failing to protect Venezuela’s southern border from the illegal influx of Brazilian gold miners that had decimated “Yanomami” people as well as for violating the human rights of *indígenas* and other poor Venezuelans (see Coronil and Skurski 1991). The encounter seems to have been designed to counter these accusations by exhibiting “the close ties which exist between the [National Guard] and our principal settlers of the national border” (Guardia Nacional 1992:1). Gómez’s troupe was asked to perform a music and dance technique associated with the *nahanamu* cycle that ordinarily calls lethal *hebu* spirits (believed to cause diarrheal and other diseases) into the community, appeases them with offerings of smoke and palm starch, entertains them, and sends them away. The healer who played the sacred rattle at the event in Caracas died a month later, and the epidemic began shortly thereafter. People thus criticized Gómez for dancing for *criollos* and for failing to offer palm starch and tobacco to the spirits, leading them to return to the delta and cause an epidemic. By retelling narratives about the Persian Gulf War, Gómez seemed to have been looking for explanations that might get him off the hook.

When I returned to Mariusa in June of 1993, Fernando Rivera, the most prominent curer in the community, took me aside before a health education meeting. As we hid from the throng toward the back of the house, squatting behind a huge metal ice chest and next to piles of salted, pungent fish, Rivera whispered,

I’m going to tell you about my dream. This disease began when the sun arose and began to shine in the sky. The house of this *hebu*, “Poison,” is there [points toward Trinidad]. This poison that comes from up there is just like the *hebu*’s poison, and that’s what started it, that how my dream goes. That “Poison” is a *hebu*, cholera; his poison arose in order to exterminate the Warao, to finish off all the Warao. My dream is really powerful!

on which they rest. Venezuela was in the midst of a profound crisis in 1991–93. The Bolívar's value against the dollar had slipped steadily, dropping from 4.5 to 1 in 1983 to nearly 700 to 1 in 2000. Fluctuations in oil prices and the weakening currency complicated service payments on Venezuela's \$30 billion foreign debt. Inflation rose. Efforts to balance the budget and neoliberal reforms included substantial cuts in public services. Public expenditures on health, which had previously reached a high of 5.2 percent of the gross domestic product, stood at 2.56 percent in 1991 (Jaén 2001:95). 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). In 1992, the two major parties that had controlled political life since the restoration of democracy in 1958 were discredited, and Lt. Colonel Hugo Chávez Frías led two coup attempts.

One locus of the wiggle room between pedagogical and performative modes of constructing subjects involved medicalization, imbuing social and political-economic relations with biomedical meanings. Bruno Latour's discussion of modernity is useful here. Latour argues that it was not scientific thinking per se that fueled modernity but, rather, the construction of cultural domains of "society" and "science" as separate and autonomous. Science was deemed to be derived from a sphere of nature that existed apart from humans; Enlightenment thinkers viewed society, on the other hand, as constructed by humans, a position that is well exemplified in John Locke's (1960) political theory. The ideological and social wellspring of modernity, according to Latour, involves two contradictory ways of relating these two realms. On the one hand, the two are constantly linked through networks of hybrids that join social with scientific and technological elements. The work of "purification," on the other hand, seeks to erase awareness of these connections to maintain the illusion that science and society are autonomous realms. Purification has, in Latour's estimation, been a central preoccupation for societies that claim to be modern, even if they implicitly construct hybrids. Failing to engage in the work of purification, drawing explicit attention to hybrids, or both, marks subjects as premodern.

One of the major thrusts of official explanations of the cholera epidemic is to suggest that bearers of "*indígena* culture" cannot distinguish between society and nature. *Indígenas* are purportedly thus unable to realize that cholera is caused by a natural phenomenon, a bacteria. Reporters and public health officials commonly assert that *indígenas* attribute the disease to hebu, glossed as "evil spirits," even though the term also refers commonly to diseases. Unable to distinguish natural from social phenomena, *indígenas* reportedly rejected physicians in favor of "shamans"; once again, this stereotype

contradicts the massive exodus from the delta to the mainland to be closer to medical facilities (and covers up the way that government officials forcibly returned people to the delta). Having purportedly failed to distinguish between nature and society, *indígenas* themselves get thrust into the natural category, projected as living like animals, as responding to natural dictates. Just as Venezuelan social and political relations were thrown into a deep crisis, upsetting models of citizenship and civility, this performative projection of the *indígena* category onto a frightening new situation permitted a performative construction of *criollos* as possessing the agency and intelligence needed to adapt to changing national and global circumstances.

Conspiratorial narratives seem to involve a category error, placing cholera in the biomedical sphere (as having been caused by a bacteria) and at the same time granting a parallel etiological status to questions of national, binational (Trinidadian–Venezuelan), and international politics, transnational capitalism, and race relations. Worse yet, they mix up categories, joining *Vibrio cholerae* to military and genocidal strategies. Here they illustrate what Katie Stewart (1999) characterizes as a common feature of conspiracy theories, desire to transcend the normal boundaries of categories. And it is not just narratives told primarily by people classified as *indígenas* that violate these canons. A view widely held in Venezuela envisioned cholera as a political smoke screen invented by the government to keep people from thinking about political and economic problems; this conspiracy theory places a biomedical phenomenon in as explicitly political a realm as did the notion that the epidemic constituted an attempt on the part of the state to complete a 500-year-old genocidal land expropriation campaign in the delta. If one thinks in modern terms, as defined by Latour, it seems clear that these formulations must be excluded from public discourse, from newspapers, official reports, clinics, and government offices, because they explicitly conflate nature–science with society–politics.

Nevertheless, the creation of hybrids that conflate modern categories is only one aspect of conspiratorial narratives' epistemological effects. If one were to attend to this dimension alone, one would collude with the state in covering up how the conspiracy theory narratives simultaneously reveal problematic dimensions of the hybridizing work done by official narratives. Shrewd observers in Venezuela commented on how physicians and public health officials were inconsistent in their dedication to the work of purification. If a cholera epidemic had emerged in neighboring Sucre state, why were residents of the fluvial area not warned about it? Why were clinics understaffed and understocked when the epidemic began? By pointing out that *indígenas* did not always get infected when they ate crabs and that *criollos* ate crabs as well, some narratives

challenged the official racial hybrid that relates crabs, *indígenas*, and cholera. Other stories challenge the limits of official purification practices, drawing attention to the regional epidemiologist's failure to investigate how the transmission of *Vibrio cholerae* was linked to the hydrology and ecology of delta waters, as did the assertion that the epidemic might have been started by fishermen from neighboring states or by the ballast of ships entering the delta. Our supposedly premodern storytellers suggest that he was too enthralled with a hybridizing narrative that he played a key role in creating, the crabs-race-cholera story, to systematically pursue the work of purification.

These narratives outline the networks that connected the complex ecology of the delta with national economic policies and transnational corporate enterprises that proliferate in a petro-nation and a region in which oil, petrochemicals, bauxite, steel, and other industrial commodities are transported through delta waters and in which a transnational fishing industry flourishes. Although few readers might be convinced that the 1991 Persian Gulf War caused the epidemic, these stories draw attention to the effects of U.S. military activities on natural environments, diseases, and human populations. Suggestions that *criollos* dumped barrels of poison into the river or sent malevolent spirits to kill *indígenas* point to suppressed issues of environmental justice, to the way that race relations, economic exploitation, and land appropriation link environments, politics, and populations. Finally, delta narrators exposed the profoundly social constitution of a medical regime that distributes health services along racial lines, rendering some bodies expendable. It would seem that official explanations of the epidemic involve no less of a "curious leap in imagination" between natural and social domains than conspiracy theories do. Michael Bar-kun argues that conspiracy theories flourish in subcultures that distance themselves from authoritative knowledge and are "intrinsically receptive" to all forms of "stigmatized knowledge" (2003:26). Although this statement may be true for the narratives that circulate among the white North Americans with whom he is primarily concerned, it certainly does not apply to people who sought alternative explanations for the cholera epidemic. They were hungry for official information, which they incorporated into their own narratives in a wide range of ways—including as definitive evidence, possible hypotheses, discourses to be critically analyzed, and objects of ridicule. Note the parallel to Anita Waters's (1997) finding that African Americans who embrace conspiracy theories tend to be better educated, more politically active, and in closer touch with problems of their community than are skeptics.

At the same time that conspiracy theories challenge official hybrids, they call into question a key element of Latour's formulation. Latour draws on anthropology in arguing for the constructed nature of the categories of

science and society. He challenges Rousseauian notions that "primitives" or "premoderns" live close to nature or that the social categories they use are automatically derived from natural ones.¹¹ Latour goes on to suggest that anthropologists demonstrate that premoderns do not see nature and society as bounded, autonomous spheres; the work of purification is unknown in such societies. He thus suggests that modern and premodern societies are in fact separated by virtue of "the premoderns' inability to differentiate durably" (1993:133; emphasis added) between hybrid social-scientific-technological networks on the one hand and the conception of society and nature as autonomous on the other. Telling these conspiracy narratives would thus seem to shape the social position of the tellers. If getting cholera demonstrates that individuals and communities lack scientific knowledge, telling conspiracy narratives further proves their premodern status by showing that they cannot distinguish scientific and social spheres. But these narratives demonstrate just the opposite, reading the purifying claims of official pronouncements with sufficient subtlety to reveal their contradictions and to expose the implicit hybrids that such accounts support. These conspiracy theories seem to embody a premodern epistemology less than they confront social and material gate-keeping mechanisms that exclude their narrators from privileged domains of knowledge and communication. Donna Haraway (1997) criticizes Latour and other science studies scholars for leaving intact narratives that privilege white male constructions *and* deconstructions of nature and science, thereby continuing to silence the constitutive role of race, gender, and sexuality in making technoscience and shaping categories of difference. These conspiratorial narratives reveal how quickly scientific claims to systematically pursue purification and denials that competing players purify fall apart logically when the constructions of race, gender, and sexuality that sustain them are exposed. Revealing logical absurdities and callous claims of modernity is, unfortunately, not tantamount to disarming them, given that race also shapes projections of scale.

Local, national, and global: Scaling races and racing scales

A second slippage between pedagogical and performative processes is evident in the construction of local, national, and global perspectives. Critics have challenged received reifications of "local" and "global" and the assignment of individuals and populations to one category or the other. Leslie Sklair (1995) argues that scholars should not speak of "global" and "local" domains but of "globalizing" and "localizing" forces and agents. Zygmunt Bauman (1998) suggests that globalization and localization shape the politics of inclusion and exclusion. Social fragmentation,

differentiation, and inequality, which Bauman sees as fundamental dimensions of globalization, fix some people in space and restrict their access to the globally circulating capital and culture that others enjoy; getting localized while others get globalized, accordingly, “is a sign of social deprivation and degradation” (1998:2). Roland Robertson (1995) suggests that localization is imposed, thereby producing a loss of agency and freedom and creating passive local viewers of global actors and processes. Michael Hardt and Antonio Negri (2000) argue that the production of local identities lies at the heart of the logic that organizes the globalized “Empire” and masks its biopolitical discipline.

The cholera epidemic provided an excellent discursive terrain in which to construct notions of local, national, and global spheres. In official accounts, *indigenas* got cholera because they were incarcerated by local knowledge. Thoroughly embedded in their immediate natural environment, their knowledge base was limited to the information that could be derived from the environment in direct and corporeal terms. *Indigenas* are described as incapable of adopting national or global perspectives and, thus, as excluding themselves from these domains. Politicians and *criollos* in general contrastively become national subjects, deriving their identities and ideologies from their respective statuses as representatives of the state and as Venezuelan citizens. Public health officials construct themselves as possessing global scientific knowledge that enable them to be national subjects and embody discursive frameworks articulated by such international bodies as the WHO and the Pan American Health Organization (PAHO). The scalar dimensions of these subject positions are seen as flowing naturally from the location of their attached bodies in terms of race, class, symbolic capital (such as a medical degree), and institutional nexus.

Conspiracy theory narratives disrupt these automatic equations of race and class positionality with scalar affiliation, making the notion that members of “traditional” communities cannot see beyond local horizons or rigid cognitive patterns and fixed points of reference seem ludicrous. Without surrendering the right to include hebu spirits in their narratives, delta residents quickly placed cholera within a global frame of reference tied to recent historical events and changing technologies, social relations, and modes of production. People often characterized as quintessential exemplars of a localized, premodern, traditional world tied cholera to national and regional political institutions, state policies, international relations, and global commerce. Given their claims to global knowledge, one might presume that public health officials would place the epidemic in a global frame of reference. Nevertheless, their accounts of the epidemic are localized, focusing on the “local” culture and the geography of the delta; their imagination seldom extends beyond the con-

finer of the region or the temporal frame of the epidemic. In short, the people classified as premodern subjects travel much farther than health professionals in explaining the epidemic. As Frederick Jameson (1992) suggests, conspiracy theories embody a process of cognitive mapping in which people attempt to relate local experiences to the global system of late capitalism. I would argue that many of these narratives go beyond *articulating* links between localizing and globalizing processes to question the ways these domains are produced, the boundaries that separate them, and the naturalizing processes that seek to make them seem real. Their appreciation of the crucial role of shifting modes of production and the organization of transnational capital is striking.

The classic locals thus took on the role of globalizing agents, tying the epidemic into broader discursive and political-economic frames. But I do not think that one should spend too much time enjoying the humor of this apparent flip-flop—taking official narratives to be local would reproduce the illusion that health professionals “discovered” them in the midst of the crisis, thereby accepting the way they disconnect the epidemic from larger economies of narrative, health, and social inequality. Institutional accounts were informed by media stories of ceviche as cholera vector and of poverty, race, and culture as causal factors that had already achieved a worldwide distribution through international press agencies, official publications of the WHO and PAHO, and works published in leading international journals by renowned epidemiologists (see Briggs with Mantini-Briggs 2003).

True, the conspiracy narratives involve impressive leaps of scale, as they connect the deaths of relatives and neighbors with racial conflicts, national policies, international relations, and transnational corporations. But official narratives also create magical scalar effects, such that an imagination of one family’s trip to the coast to consume crabs in a ritual feast (see *Notidiario* 1992c) can place some twenty-four thousand people “at risk” for cholera. Here culture does explanatory overtime, becoming the basis for what Farmer (1999) refers to as “immodest claims of causality.” Latour is right: It is the epidemiologists’ claim to purity, to use “all angles of the scientific vision,” in the words of the regional epidemiologist (*Notidiario* 1992a)—and only them—that helps to make these hybrids powerful and render their processes of construction invisible. Public officials scaled impressive heights as they used a synecdochic logic in making individual bodies stand for social bodies; diseased bodies were then excluded from the body politic, whereas their uninfected counterparts embodied the sanitary citizenship that represented the nation. Conspiracy narratives read diseased bodies as signs of a diseased body politic, showing how racialization fostered an epidemic that lay at the core of a sick racial project.

Latour (1999) suggests that one of the strengths of the field of science studies is the way it resists local versus universal dichotomies by revealing the networks that localize seemingly decontextualized global science and that infuse global connections in the creation of minute particulars. Nevertheless, Latour himself seems to buy into these problematic notions of scalar differences. Although he portrays the divide as constructed, Latour argues that the terms *modern* and *premodern* or *primitive* refer to distinct social types that contrast by virtue of the premoderns' "obsessive interest" in nature–society hybrids, the limits they impose on the scale of social relations, and their "localization by territory" (1993:133). He suggests that one of modernity's defining features is scale, the construction of technologies and epistemologies that embrace larger and larger populations and regions. Here Latour accepts a key mode of constructing premodern peoples—the notion that premoderns are limited to local perspectives as modernity becomes global in scale. As Richard Bauman and I (2003) argue, the opposition between traditional subjects, who are inexorably embedded in local environments, and cosmopolitan subjects has been a central epistemological and political component of modern discourses since the 17th century. Latour becomes implicit in reproducing social inequality in his conception of scale just as he does in pointing to "the premoderns' inability to differentiate durably" (1993:133) between science and society.

As critical geographers suggest, spatializing practices are crucial means of legitimizing social inequality and generating social and political–economic effects (see, e.g., Soja 1989). Conspiracy theory narratives reveal the thin imaginations and thick erasures that underlie the spatialization of race in the delta. The scope of the spatial imaginations of people classified as *indígenas* became quite apparent during the epidemic in protest marches that appropriated the local space of national identity, the plaza dedicated to Simón Bolívar, the national liberator. The demonstrators were quite aware that they were participating in a transnational indigenous social movement and that their action was linked to protests of the Columbian quincentennial that were taking place all over the Americas. As cholera refugees took to the streets of Caracas, the capital, and other cities to ask for handouts and to call attention to their situation, the government attempted to block, through military checkpoints, the departure from Delta Amacuro and neighboring Monagas state of any body that looked *indígena*. When Mariusans, the purportedly most localized group, were confronted with a medical emergency, they took the patient involved to Trinidad. There they attempted to negotiate with the Trinidadian government for health care, arguing that the Venezuelan state had demonstrated its inability to protect their health rights and that they contributed to the Trini-

dian economy by selling crabs. The Venezuelan ambassador was called in as an international scandal erupted, a group of politically adept *indígenas* having attempted to negotiate an international treaty. In protest marches, in the growing urban presence of delta *indígenas*, and in the trip to Trinidad, people demonstrated with their bodies the same scope of spatial imaginary they performed in their explanations of the epidemic. One might accordingly want to amend the view expressed by Bauman and Robertson. Racialized and poor subjects need not get localized, fixed in space, cut off from transnational culture and capital, or become passive to be stigmatized as local—localization is a powerful imagination that can be imposed on people whose own practices of imagination are quite global.

As Dipesh Chakrabarty (2000) has recently suggested, temporal imaginations are no less effective than spatial projections in reproducing social inequality. Official accounts constructed *indígenas* as incarcerated by a "timeless" or "millenarian" culture; being confined to reproducing traditional patterns mechanically, "they" were supposedly unable to size up a changing reality and incorporate the new practices needed to save their own lives. This "denial of coevalness" is, as Johannes Fabian (1983) suggests, a key feature of colonializing logics, including their anthropological inflections. Here, too, the joke is on the politicians and the epidemiologists, who seem to turn their backs on history, failing to link the epidemic in Delta Amacuro to the dissemination of cholera in Venezuela, the Latin American epidemic, and the effects of neoliberal policies on health care. Conspiracy theories are, contrastively, highly historical, placing the epidemic in terms of events taking place as the epidemic was emerging. My imaginary does not connect cholera in the delta to the Persian Gulf War in as direct a fashion, but others' attempts to link the epidemic to conflicts produced by the U.S. military–industrial complex challenged some of my own purifying and localizing tendencies. These conspiracy narratives thus challenged the politics of scale that sustain racial imaginaries and naturalize their tremendous social and political–economic effects. Like the challenge to scientific purifying and hybridizing practices, however, these performative violations of scalar positionalities and their epistemological presuppositions did not, as it were, tip the scales. *Indígenas* simply could not go public with this challenge.

Material limits to the circulation of public discourses

I draw on Michael Warner's (2002a) discussion of public discourse in pointing to a third way that subjects are split through pedagogical and performative practices.¹² Warner reveals how the production of public discourse revolves around a number of fundamental contradictions.

To become public, a discourse must address a public as a collection of “already existing real persons” (2002a:82) with some known, specifiable commonalities, and its success depends on the interpellation of the discourse by persons who recognize themselves as members of a collectivity that is addressed. Nevertheless, public discourses are, in Warner’s terms, “self-creating” and “self-organizing”—the public is actually created through the circulation of discourse as people hear, see, or read it and then engage it in some sort of way. State institutions cannot accurately predict the public that will receive a given message or how that public will be constituted—for example, through interest, ridicule, or protest. This “autotelic” (Warner 2002a:51) process of reification is not accidental but constitutive: “The notion of a public enables a reflexivity in the circulation of texts among strangers who become, by virtue of their reflexively circulating discourse, a social entity” (Warner 2002b:11–12). Nevertheless, it must be imagined as real in the course of both production and reception. This ideological construction of “the public” permits the illusion that public discourses reach out to all possible readers, listeners, or viewers. Warner notes, however, that “there is no speech or performance addressed to a public that does not try to specify in advance, in countless highly condensed ways, the lifeworld of its circulation” (2002a:82).

Since the 19th century, state discourses on cholera have constituted quintessential pedagogical projects, providing modes of distinguishing sanitary citizens from unsanitary subjects and new performative techniques for mapping populations in these terms. Narratives carried in newspapers and television broadcasts seem to address people in general and provide a space in which officials, politicians, reporters, and citizens all speak. Public health discourses project a common participation in a national project, the idealized interpellation of every body by biopolitical practices to ensure a healthy body politic. Nevertheless, this ideologically constructed image of the circulation process performatively projects a hierarchical ordering of distinct publics. Public health officials, especially the director of the Regional Health Service and the regional epidemiologist, are cast as producers of public discourse about cholera and as official mediators of MSAS, PAHO, and WHO messages. Politicians must recontextualize these statements in the form of policies and material resources; they are criticized when they try to produce information on the epidemic or resist the authority of public health officials. Sanitary citizens, middle-class individuals who are expected to engage in hygienic practices and respect medical authority, must demonstrate that they are knowledgeable, that is, that they can reproduce verbally the rudiments of the public discourse.

Unsanitary subjects, members of working-class and poor populations, must reproduce the official discourse

bodily by adopting hygienic practices and demonstrating subservience to medical authority. When their words appear in public discourse, they are primarily affective in content, expressing fear of the disease or anger at official inaction or begging officials to save them. This class-defined position is further split in racial terms; working-class *criollos* are deemed ignorant but educable, whereas *indígenas* are projected as incapable of reproducing the official discourse, either verbally or in bodily practices, thus marking themselves as the natural targets of the disease. The participation of *indígenas* in public discourse is thus citational, as captured by reporters’ questions and photographs. Their role in the pedagogical project is not, in the end, that of recipient or interlocutor—because they are deemed to be incapable of understanding it; they, rather, become points of reference for performatively constructing *criollo* citizens during a time of political and economic crisis. The hegemonic model of discourse circulation suggests that one can only escape the premodern world if one thoroughly internalizes state discourse by becoming a sanitary citizen; because *indígenas* cannot become sanitary citizens, they are unable to escape. The split between pedagogical and performative practices that emerges through the ideological construction of discrepant publics imagines *indígenas* as doomed to extinction, a message that officials often expressed in private.

This performative projection of hierarchically ranked roles is coded not only in what each party presumably says but also by virtue of the social and institutional space through which its occupants enter this imaginary process. Public health officials, politicians, and reporters are generally pictured in government offices or places where meetings take place, and high officials are doing the talking. Working-class *criollos* are imagined as listening to lower-status professionals in less prestigious institutional spaces or on the street. *Indígenas* are generally caught in the act, behaving in ways (whether on the mainland or in the delta) that reflect an utter lack of awareness of what they should be saying and doing. When pictured as patients, they seem to be passively awaiting either death or recovery but not actively absorbing information about cholera. The constant stream of public discourse about cholera in newspapers and television reports is reinforced by visual images of these parties in their respective social spaces and roles, their bodies and faces reflecting the agency or passivity with which they are credited.

Conspiracy theory narratives construct the lifeworld of the circulation of information about cholera in multiple ways, many of which challenge these constructions. Actors who lack professional and middle-class status, including fishermen, activists, and community leaders, cast themselves as taking an active role in the circulation and often the production of discourse about the epidemic.

They witness the key events in cholera transmission—by observing the movements of commercial vessels or clandestine acts of genocide, critically assessing clinical practices, gathering information as amateur scientists, or consulting spirits. Rejecting their relegation to the status of passive reproducers of official interpretations, narrators cast themselves as possessing great powers of interpretation and evaluation, of picking up on facts and connections that others have missed. Some accounts cast discourse about cholera as a dialogic space in which different producers confront one another and debate their epistemological differences, sometimes achieving composite perspectives. For example, some *indígena* patients recounted exchanges with physicians during which they challenged the crab–cholera hybrids and forced their doctors to admit that social and political factors complicate biomedical stories.

Let me not romantically celebrate the effects of these interventions, however—they largely failed to disrupt the ideological construction of how cholera discourse should circulate or the performative projection of hierarchically ranked roles. Their failure lies not in too much or too little imagination or, following Mark Fenster's (1999) critique of the political limits of conspiracy theories, in constructing their own marginality by giving up agency to imagined loci of power. The problem, rather, lies in what Warner identifies as the "material limits" on the circulation of public discourse—"the means of production and distribution, the physical textual objects themselves, the social conditions of access to them—and by internal ones, including the need to presuppose forms of intelligibility already in place, as well as the social closure entailed by a genre, idiolect, style, address, and so forth" (2002a:54–55). All public discourses are exclusionary, because features of their content, discursive organization, and mode of transmission affect who is likely to come in contact with and interpellate them. Reporters cast public health officials as what Stuart Hall et al. (1978) term the "primary definers" of the cholera story, shaping the sort of narratives that could be told, the authoritative languages in which they could be articulated, and what parts different players would be accorded. Public discourse about cholera was thus defined vis-à-vis the biomedical authority of public health officials. Conspiracy theories, told by people not ratified as producers of knowledge about the epidemic and involving competing practices of purification and hybridization, were seldom able to enter public discourse. They spread rapidly through both fluvial and mainland areas, primarily through rumor, but they were not able to challenge official narratives in public discourse. The unequal distribution of symbolic capital, including biomedical knowledge, and people's exclusion from institutional power relegated the ideological models of discourse circulation associated with conspiracy theories to circulation

in the form of rumors, of narratives excluded from the media and from official institutional contexts. Even when community representatives came to the offices of the newspaper or radio to criticize official efforts, their words were ventriloquized as pleas by pathetic figures unable to obtain government assistance.

The political limitations of these conspiracy narratives thus seem to lie less in their epistemological content or narrative structures than in social and material constraints on their circulation. Most discussions of conspiracy theories presuppose a sort of discursive egalitarianism, as if such theories existed on a level playing field (to ironically invoke one of the most problematic neoliberal metaphors) with academic, state, corporate, and media competitors. But some narrators enjoy greater access to the social and institutional positions that render people's words authoritative, to sites for mastering technical vocabularies and discursive strategies (such as the university in which I work), and to the newspapers, official reports, radio and television programs, websites and e-mail addresses, court cases, and meetings that place narratives in public circulation. Racial formations, biomedical authority, and social and institutional positions led journalists to print the words of public health officials as the truth about cholera, whereas racialized delta residents got onto the front pages of newspapers only as photographic images of dirty and diseased bodies or through brief quotes that expressed terror, confusion, and passivity. The same process of erasure turned images of their bodies and evocations of their voices into evidence that confirmed the truth of official narratives.

It is precisely the failure of cholera narratives to create a viable counterpublic that points to the need to rethink Warner's formulation. His essay is about possibilities, about the creative capacity of texts to imagine publics and of people to bring multiple publics and counterpublics into being by exercising divergent ways of responding to them. Warner mentions these "material limits" and then moves on; that the question of such constraints does not become central to his analysis might be related to his primary focus on publics that are white, middle-class, and North American, even as he thinks substantively about questions of gender and sexuality. When the texts in question are circulated primarily by persons who are not white, middle-class, or North American, the issue of material limits comes to the fore. The focus then becomes less one of people's ability to imagine themselves as a public and the sort of reflexivity entailed in this collective act of recognition than of the political–economic barriers that prevent their reflexive discourses from becoming public. In the end, these material inequalities must be hidden from view to sustain the idea that public discourses are "self-creating" and "self-organizing" or the notion that publics are created through the circulation of

discourse. And as racial and global inequalities become more acute, attention to the limits of publicity become increasingly important.

Return trips to the bakery

I have returned to the passageway between the bakery and street, between life and death, a thousand times since first encountering the mother and her children. One visit came a few days after that initial encounter, as I returned to pick up my dilapidated bicycle, abandoned during a torrential rainstorm. Pérez was back—right on the edge of the bakery entrance. She was relaxed and smiling. The infant was still malnourished, its distended stomach and tiny arms quite visible under a white tank top. But he was smiling, making eye contact, and greeting me alternately with smiles and looks of apprehension. Pérez told me that in the five days since I had last seen her, the child had nearly died. A physician had given the child medicine for diarrhea, and Pérez had thrown away the baby bottle in favor of her own milk. Her son was gnawing happily on a hunk of bread. Pérez noted that during her last visit to the hospital, the physician declared that the child was well.

Having returned to the strategic space where customers were forced to confront her outstretched hand before entering the bakery, Pérez redefined my role as that of a rich *criollo* who should give her a contribution, which I did. We drank sodas. I chatted with the daughter, Julia, whose legs were wrapped in a big piece of paper as protection against the cold air blasting from the bakery's air conditioner. Some customers gave me puzzled looks, wondering why I was talking in Warao to begging *indígenas*. Others just gave us dirty looks. We were still caught in uncomfortable roles and, as my teacher Victor Turner put it, liminal spaces, on the border of a bakery, several social worlds, communication, friendship, and economic exchange. Pérez's baby was still quite susceptible to a diarrheal or respiratory infection. But after hearing so many heartbreaking narratives in the delta, and after worrying about that baby for nearly a week, this possibility wasn't on my mind as I left for a meeting about racial injustices in the criminal court system. I was happy.

I returned to this space often in my imagination following my return to California in September of 2002. My own daughter, Feliciano, came to spend a few weeks with me. Twenty-four years old, blond, Stanford University graduate. A former student of gifted writer Tobias Wolf. Political and environmental activist. I had raised her for many years as a single parent, long before it was acceptable for men to be single parents of toddler children, and Feliciano was one of my deepest connections with the world. She was on her way to New York to begin her career. We shared a beach cottage in San Diego, enjoying the power of the ocean, running together along the beach. She contracted mononucleosis. Her fever hovered around 102 degrees, and she had a near constant headache. She was far more distrustful of biomedicine than anyone I met in Delta Amacuro, refusing even to take aspirin. She was so sick that she could only lie on the couch and watch television. Images of the sniper killings in Washington, D.C., a city in which she had lived. The midterm elections. And the departure of massive, bellicose vessels for the Persian Gulf from San Diego military installations. She talked to me frequently about watching the ships pass under the Coronado Bridge, out of the port, heading for a war foretold. Feliciano became worried about the sort of world that lay ahead for her and for all of us. I nursed her. We were closer than ever. One night, as I watched her sleep, I imagined that her life could be in jeopardy, even if this was biomedically implausible. My mind went back to those times in the delta when I wondered if I could survive such a loss.

On November 9, 2002, she took her own life, symbolically jumping from the bridge that had marked the passage of those vessels of war toward Iraq. She left me a note that spoke of her deep love for me and how deeply she felt the pain of the world. Experts tell me that her anxiety about the future was exacerbated by a change in her brain chemistry, induced by the mononucleosis. I still feel blind. I was with her nearly constantly for six weeks, but I didn't see it coming. I blame myself for every sign that I should have perceived, every intervention that I could have made. But feelings of guilt do not even come close to the sheer impact of her absence. My life, as I knew it, ended when she died.

During the longest night of my life, the sleepless hours that followed her death, I constantly heard the voices of women in Delta Amacuro. They sang the collective poetry that is performed after anyone dies, even the smallest infant. They were singing for Feliciana. Friends in the delta debate whether I heard the voices of sisters who had already passed into the spirit world or whether I had internalized the verbal formulae and generated the verses in my own head. I don't care—these voices sustained me that night. I felt, for months, as if all of my viscera had been ripped from my torso. Every moment of every day since that time has been filled with pain, albeit less acute than in the days that followed Feliciana's death. When life seems unbearable, fragments of these laments come back to me, helping me remember, helping me go on.

My relationship to my research on death in Delta Amacuro has changed a great deal since November of 2002. It has taken me a while to reconnect with its scholarly representation. Completing this essay constitutes a step in that direction. Important here was returning to W. E. B. Du Bois's powerful reflection "Of the Passing of the First-Born" in *The Souls of Black Folk* (1990). Du Bois uses the death of his toddler son as a site for reflecting on his own positionality as a man and a father as well as an African American. He beautifully articulates the death wish that I share, echoed in so many delta laments, in which parents ask why they could not have died instead of their child—and if their own deaths will provide a reunion. His son's passing prompts Du Bois to reflect on the "unvoiced terror" of his life, the violence of racism; he accordingly experiences "an awful gladness" that his son has escaped the color-line. Du Bois asks—like Toni Morrison in *Beloved*—if his son might not be better above the Veil (1990:151, 154). But Du Bois goes on to suggest that all lives "are larger and purer by the infinite breadth of that one little life" (1990:153), turning his grief into a site for imagining that the world might "dawn some mighty morning to lift the Veil and set the prisoned free" (1990:154). Du Bois challenged me to turn the most difficult moment of my life into a space for asking more critical questions of myself and my work and for imagining more clearly how I could contribute to a more just world.

I am sure that you will have guessed that another step consisted of digging up my copy of Renato Rosaldo's *Culture and Truth* and rereading the section on death, rage, and head-hunting. Renato's essay helped me imagine how it might be possible to find a deeper engagement with my own work by connecting it with Feliciana's death,

during a time in which finding meaning in life and work has not been easy. Both the honesty of his essay and its assertion that one's own scholarship is linked to formative personal experiences aided me in rethinking my connection to the people in Delta Amacuro and to you, the members of my imagined audience.

I find, nonetheless, that losing Feliciana has produced different effects in me than the ones that Renato describes. My predominant emotion has been sadness; rage figures much less prominently. Whether differences in our socialization, personalities, or, at least in part, how our emotional responses to death were conditioned by Ilongot and Warao friends is responsible I cannot say. Although connecting my research and recent events in my own life has not convinced me that I better understand the experience of delta parents, even if I qualify the term as "affective understanding," it has transformed my relationship to what people have taught me about the death of their children.

My first reaction has been a shift in my positionality in relation to what people have taught me about the death of their children. Feliciana's death has changed my subject position in relationship to the death of children in the delta—I no longer look at this subject from the outside, wondering what it feels like and how people survive it. Losing a child now provides a kaleidoscope that casts my life into changing images, as my struggles to face powerful emotions rotate the lens. I had thought that the people of the delta were informing me about their own lives. It turns out that they were preparing me for my own. For years I had had to confront the grim fact that children die and that their parents suffer horribly. I had lost my bourgeois North American sense that the children of good parents never die, except in the event of a rare cancer or a freak accident. I had lost any sense of invulnerability, and I had learned that the death of a child is one of the most powerful traumas that a human being can bear. And that turning pain into memory is an active, poetic process, one that is crucial for survival. I think that this knowledge saved my life or, at least, my sanity.

There is, I think, a more general lesson here. Arthur Kleinman and Joan Kleinman (1996) warn that representations of social suffering can evoke a politics of pity that ends up increasing the perceived social and political distance between people who face inhumane conditions and those who read about them; Das's (1995) moving account of how corporations and states excluded the voices of Bhopal survivors from legal venues in which their claims were adjudicated provides a striking example. One of the most important contributions of anthropologists to understanding the increasing gaps between rich and poor has been to describe the political economy that distributes the incidence of infectious and chronic diseases and access to health care by race, nation, gender,

and class. Anthropologists have turned their narrative skills to transforming epidemiological statistics into human portraits that enable readers who enjoy more than their share of health and wealth to identify with the lives and deaths of people who get the short end of the stick.

I am thinking here not only of the work of Farmer (1992, 2003), Scheper-Hughes (1992), and others but also of Clara's and my *Stories in the Time of Cholera* (2003). We argue there that the Latin American cholera epidemic demonstrates how deeply people who live in privileged sectors of wealthy countries are implicated in these increasingly fatal health inequalities. When Feliciano died a week after the first copy of our book arrived, this message was suddenly transformed for me into a powerfully visceral sense that I could not afford to place myself in a distanced position in relationship to the stories that Clara and I retold there. I was struck by the obvious connection—that Feliciano had similarly imagined global social suffering and her own geopolitical positionality vis-à-vis vessels of economic and military power and U.S. wars directed against Iraq. My own survival seemed to depend on being able to place my own experience in intimate relationship with the narratives that I had heard—and partially internalized—from delta parents. Scholarly stories of the social suffering of poor, racialized, and immigrant populations can effect a denial of coevalness, in Fabian's (1983) powerful phrase, the narrative location of Others in worlds that seem to occupy utterly incommensurate temporal and epistemological spaces. They can then construct their own authority by presenting their texts as a magical means of crossing these chasms. In her discussion of the Vietnam Veterans Memorial, the Persian Gulf War, and the AIDS Memorial Quilt, Marita Sturken (1997) points to how practices for turning death into memory can open up critical spaces for examining the politics of erasure and inequality. I think that anthropologists might thus develop strategies that place our own efforts and those we describe within a broad range of practices for rendering visible the ghosts created by scattered hegemonies, both proximal and distal, and for challenging the political economies that produce them.¹³

My point is not simply to urge a politics of identification, to suggest that all people are in the same boat, all victims of global capitalism. A second reflection on my experience of Feliciano's death and the way that people in the delta respond to their children's deaths provides me with an equally visceral sense of a key difference that separates the two. After Feliciano died, I was able to collaborate with my father in writing an obituary for her, and our narrative was published in several newspapers. To communicate with others who mourned her, I created a website in her memory. My colleagues in ethnic studies at the University of California, San Diego, established a graduate fellowship in her name, tying the preservation of her

memory to the struggles for justice and knowledge that she advocated. Less than two weeks before the most recent U.S.-led war against Iraq began, I was invited to speak at an international peace conference that took place in the Mexican Congress. In concluding my remarks, I connected the implications of the War on Terrorism and the impending war against Iraq with Feliciano's death. Both the talk and the minute of silence that the organizers dedicated to her memory, were carried on the Congress's national television channel. And I am able to tell fragments of this story to you, colleagues who communicate through the pages of the *American Ethnologist*. As my own practices of mourning continue to grow in relationship to what people do in the delta, I am struck by the privilege that enables me to turn my representations of Feliciano's death into public discourse, whereas the powerful narratives told by relatives about death in the delta get erased. And this brings me to the broader implications of conspiracy theories.

It is crucial to keep in mind the political-economic parameters that shape how some narratives are admitted to official regimes of truth and how others become conspiracy theories. When debates get medicalized, inequalities associated with access to symbolic capital, institutional positions, and the media are rendered invisible precisely at the point at which they intersect with hierarchies associated with clinical medicine and public health. As the field of science studies suggests, control over the magical space of the laboratory—where discourse is converted into truth and statements regarding substances extracted from a few bodies become modes of explaining a regional crisis—is crucial. Because the corner of the Tucupita hospital in which feces are turned into cholera statistics is controlled by the regional epidemiologist, only official statements, not those marked as conspiratorial, can pass through it. Similarly, only the nation-state is granted the right, under the WHO Constitution, to convert cholera cases and deaths into statistics to send to Geneva; the potential circulation of conspiracy theories was considerably reduced by the Venezuelan state's ability to reduce some 500 deaths to 13, a figure that prevented any sort of international scandal. Similarly, those icons of biomedical authority, the manuals written in Geneva by WHO's Global Task Force on Cholera Control, reached the hands of high institutional officials, not the producers of conspiracy narratives. Racial and class constraints on literacy skills and access to educational institutions similarly restricted the ability of people who lived in delta communities to use such texts in infusing their narratives with authority. Being the possessor of a copy of the racialized pamphlets distributed in *indígena* communities conferred more stigma than authority.¹⁴ Jodi Dean (1998) may be correct in suggesting that conspiracy theories can gain authority and currency by virtue of being marginalized or suppressed, and this observation might be particularly pertinent to conspiracy narratives told by white North

Americans. But the stories told by members of communities that face structural violence on a daily basis underline the need to think about the symbolic economy of conspiracy theories in relationship to the broader political-economic conditions that shape their production and relegation to particular routes of circulation.

The economy of race that shaped accounts of cholera in Delta Amacuro suggests that the question is not simply what people can understand but what they can get publicly acknowledged for understanding. Latour does not seem to appreciate that racialized subjects do not get the same credit for their purifying work. Conspiracy theories attempt to unravel official hybrids and challenge purifying practices whenever disease burdens and access to public discourse are inversely correlated. Scheper-Hughes (1992) examines how women living in Brazilian *favelas* and how government officials construct infant mortality. A politics of rumor and distrust enables poor women to grasp the political economy of infant death and to deconstruct the official hybrids that rationalize, for example, the availability of state funds to bury poor children but not to provide them with food, medical treatment, or potable water. Historian David Arnold (1993) documents British attempts to legitimize colonial rule by claiming that only the Empire could save Indians from cholera, smallpox, and plague. He details how rumors enabled Indians to disentangle the logics and disrupt the medical and military tactics that held this ideology in place. Luise White (2000) illuminates the purifying work performed on the racializing hybrids of colonial medical and political regimes in Africa; these hybrids were articulated through claims that firemen were vampires who drained African bodies of their blood. Farmer (1992) explores rumors and speculations that shaped how people coped with the beginning of the HIV/AIDS epidemic.¹⁵ Rather than exoticizing narratives that focus on sorcery, political intrigue, or accusations that AIDS is a U.S. campaign against Haiti, Farmer demonstrates how these accounts enabled both Haitians and Haitian Americans to connect AIDS deaths with the economy of racism and the global economic exploitation that had placed them “at risk” for HIV/AIDS, tuberculosis, and other infectious diseases (see also Farmer 1999). Other studies suggest that globally circulating conspiracy theories regarding HIV/AIDS and its transmission become intimately inflected with racial, class, gender, and sexual economies wherever they are told (see, e.g., Fine 1992; Goldstein 1992; Kane 1998; Kroeger 2003), much like those concerning organ theft and transplant (see Scheper-Hughes 1996, 2000).

As in the case of the cholera narratives, one may not accept these curious leaps of imagination. Nevertheless, one would be wrong to chalk up discomfort with them simply to cultural or epistemological differences or, as does Hofstadter (1967), to paranoia. Fenster (1999:112) suggests that the paranoid quality of conspiracy theories

emerges from a sense that the narrator’s everyday life is vulnerable to danger, arbitrariness, and violence. What may seem paranoid to middle-class whites is unfortunately often realistic for racialized and oppressed populations whose everyday lives are patterned by structural violence and strategies for dealing with it. Henry Louis Gates Jr. (1988) and Patricia Turner (1993) argue that African American narratives and other genres provide means of articulating the dangers associated with being black in a racist society. Waters (1997) urges an assessment of African American conspiracy theories on the basis of the experience of racism, systematic violations of African American rights, and attempts to obtain and critically evaluate information regarding social and political crises. When people’s lives are threatened by land expropriation, economic oppression, and environmental degradation associated with global capitalism, new strategies of governmentality, and widespread death from both unknown and altogether too familiar diseases, dialogically engaging official narratives and exploring other epistemological and political possibilities provide sites for exploring strategies for survival.

My point here is not a functionalist claim that conspiracy theories are adaptive strategies used by oppressed populations. I am, rather, pointing to important overlaps between the political-economic underpinnings of the distribution of power, wealth, and violence and of the circulation of public discourse. Conspiracy theories about HIV/AIDS provide another lesson here. Steven Epstein (1996, 1997) documents the success that middle-class, white, gay activists achieved in gaining access to debates about research, treatment, and representation as the epidemic progressed; as gays entered public discourse about AIDS, conspiracy theories became less and less central. On the other hand, conspiracy theories continue to flourish in African American communities, which have enjoyed less success in gaining access to public AIDS debates (see Turner 1993).

Moreover, this is a web (and, increasingly, an electronic web) in which everyone is enmeshed. Bhabha argues that “counter-narratives of the nation that continually evoke and erase its totalizing boundaries—both actual and conceptual—disturb those ideological maneuvers through which ‘imagined communities’ are given essentialist ideas” (1994:149). Chakrabarty similarly points to the political importance of “narratives of self and community that do not look to the state/citizen as the ultimate construction of sociality” (1992:26). Some of the stories that I have summarized would seem to be prime candidates for such counter-narrative status. Insofar as they can challenge the pedagogical and performative projects of governmentality, they are of potential significance to communities that do not get labeled as *indígena* or cholera ridden.

Conspiracy theories can offer anthropologists insight into their own imbrications in the contemporary world and how to attempt progressive interventions. My own privileged position with respect to the circulation of public discourse about death in the delta did not begin when Feliciano died. In assembling our own narratives of the cholera epidemic and attempting to imbue them with authority, Clara and I conducted nearly two hundred interviews. In the delta we spoke with physicians, nurses, former cholera patients, relatives of individuals who had died from cholera, lay and institutional medical practitioners, community leaders and government officials, missionaries, entrepreneurs, fishermen, and other delta residents. In Tucupita, Caracas, and other cities in Venezuela we also spoke with politicians, missionaries, merchants, taxi drivers, journalists, and officials in a wide range of government agencies. We also interviewed officials in New York (UNICEF and other agencies), Atlanta (the Centers for Disease Control, or CDC), Washington, D.C. (PAHO), Geneva (WHO), and Dhaka (International Centre for Diarrhoeal Disease Research, Bangladesh). This research took capital of the financial sort. Our symbolic capital, medical and anthropological, enabled us to produce texts in each of these places by recording interviews. We were able to obtain copies of texts—laboratory and clinical reports, manuals, pamphlets, letters, directives, published and unpublished statistics, and newspaper articles—documents whose possession conferred social power.

I have made it clear from the start that the conspiracy narratives I report here are not the stories that I would construct in “explaining” the epidemic. The reason, I think, is not simply cognitive; it does not revolve around cultural or epistemological differences. The narratives that Clara and I tell are no less fragmentary, interested, and positioned than anybody else’s, official or conspiratorial. But our narrative practices did not have to confront exclusion from sites in which authoritative knowledge is produced, stored, and circulated—laboratories, administrative offices, archives, and the like—or relegation to the least authoritative texts—pamphlets mass produced for distribution to members of “at risk” populations. And the accounts that we produce have circulated on the radio, in newspapers, at public and closed-door sessions in which policies are debated, at academic meetings, in professional journals, and through university presses.

We thus derive tremendous privilege from the same global discursive economy that erases the narratives told by people in the delta about the deaths of their family members. By collecting narratives and creating our own, we exert some influence over the circulation of public discourse about the epidemic. This is one of the goals that have shaped our research from the beginning—to

make more space in public discourse for the deaths that have been erased. To be sure, this involves processes of ventriloquism, of replaying the voices of those generally excluded from public debates, that have been the focus of a great deal of debate in anthropology and cultural studies during the past two decades. I see no easy escape here from the politics of representation that were articulated by James Clifford (1988), Donna Haraway (1992), Gayatri Spivak (1981), and many others. My strategy has not been to insert voices that I can easily translate or identify with but, rather, to rely on narratives that evoke tension and, perhaps, disbelief on the part of readers who enjoy more privileged access to symbolic capital. Conspiracy theories are excellent objects for reflection, I think, because they raise important questions about official practices of purification and hybridization and constructions of scale and, at the same time, draw attention to their own interpretive limitations. They are particularly useful to me in that they expand my ability to think about the epidemic, its underpinnings and effects, at the same time that my lingering discomfort with them makes it harder for me to think that I have revealed truth or uncovered the real site of resistance by retelling them. I have attempted to use them not as direct reflections of life and death in the delta but to draw attention to the discursive boundaries that allow some accounts to enter public discourse and keep others out. My goal is not to gain the right to speak for people in Delta Amacuro—or billions of people who similarly are faced with abominable health conditions and practices of exclusion that limit their participation in public debates. Indeed, my confidence in my representational power is not exactly at its peak right now. I am more interested in doing what little I can to challenge those discursive boundaries.

There is, I think, an important lesson here for anthropologists who seek to confront growing inequalities. In response to critiques of the objectivist claims of past generations and the subjectivist self-positioning that followed, many researchers strive to bring multiple texts, perspectives, voices, and styles into their writing, often keeping their fragmented, interested, and imaginary qualities in view. At the same time that it may qualify our claims to epistemological authority, this move greatly *extends* our capacity for inserting ourselves into an extremely broad range of sites in which discourse is produced and circulates. In our case, research in Tucupita, Caracas, Washington, D.C., and Geneva expanded our authority for representing the circulation of discourse about the epidemic far beyond what would have emerged from the once-standard confinement to what *indigenas* in the delta said about it. The notion that anthropologists have challenged the authority of their own texts by pointing to their fragmentary and positioned nature is thus contradicted by

their efforts to gain access to an even greater range of sites in which discourse is produced and travels than can be had by any other participant in the process.

I have argued that a hegemonic vision of how public discourse circulates legitimizes both inequalities of access to information and of rights to transform one's own story into public discourse; in the mediated societies (Martín Barbero 1987) of the present, this process provides an important component of contemporary governmentality and a crucial mechanism for producing and sustaining social inequality, medical and otherwise. If, as researchers, we exploit the privileges we enjoy in this process—and attempt to increase them—without critically assessing and challenging these discursive economies, we become more deeply complicit in reproducing inequality. I want to stress that we are inserted in these power relations regardless of the content of our writing. Attempts to place suppressed stories about social suffering into public discourse and reveal how state and corporate officials legitimize their imaginaries do not necessarily challenge hegemonic constructions of the circulation of public discourse or change the rules that structure control over this process. Anthropologists who are attempting to exert stronger voices in media and policy debates cannot take for granted that they are automatically talking back to power, because their efforts draw on the power that they enjoy by virtue of their social positions (as differentially structured by race, class, and gender).

What can we do? First, we need to critically and systematically study how knowledge gets situated by virtue of its ideologically and materially constructed location(s) in the circulation of public discourse. We must go on to grasp the social and political-economic inequalities that produce these discursive cartographies. And we cannot leave ourselves out of this process. If anthropologists are truly concerned with questions of power and representation—and wish to do more than watch deadly inequalities proliferate—this focus must move to the forefront of anthropology's agenda. Second, intervene more critically and reflexively in this process. I have argued that a crucial dimension of anthropology's imbrication in this politics and poetics of social life lies in the practices that anthropologists use in locating and appropriating discourses and transporting them across the boundaries that define publics. Following Warner, we can say that each act of de- and recontextualization can contribute to redefining the boundaries and relations between publics and counter-publics. But I have gone on to argue that such participation both presupposes and reproduces the political-economic inequalities associated with the power to decontextualize discourse and recontextualize it across public boundaries. Documentation and publication thus constitute interventions into these processes, ones that affect the rights of other participants. Rather than attempting to project the

voice of the Other in public, as it were, one of the goals of a progressive anthropology must be to challenge the inequalities of discourse circulation that exclude vast classes of interlocutors—or that transform their words into pathetic statements that confirm their speakers' inability to participate in public life.

It would be foolish to think that anthropologists possess unlimited powers to disrupt these inequalities, particularly in relation to people who possess more authoritative epistemological and institutional positions and greater control over the media. But the conspiracy theories that I have retold here suggest that people who are poorly positioned vis-à-vis these same inequalities are already hard at work on this process. I think that it thus behooves practitioners to ask themselves where their work—and not just their good intentions—place them in relationship to struggles for access to and control over public discourse. These conspiracy theories suggest that in the case of discourses that speak of structural violence and genocide—or attempts to mask them—the human stakes in the struggle to shape what makes it into public discourse are high indeed.

Notes

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1. I ask readers to bear in mind that the terms *indígenas*, *criollos*, and *Warao* do not refer to bounded, discrete social groups. My analysis suggests that dividing delta residents into discrete and nonoverlapping “indigenous” and “nonindigenous” 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. To remind readers that *indígena* and *criollo* are particularly problematic terms, they are italicized throughout this article. All of the names of delta residents that appear in this article are pseudonyms. The population figures are taken from the 1990 census of Delta Amacuro state and the 1992 *Censo Indígena* (Oficina Central de Estadística e Informática 1992, 1993).

2. 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 that Clara Mantini-Briggs and I conducted in Caracas on July 2, 1999.

3. This figure is, of course, only an estimate. We visited every part of the delta during this period. In each community, we interviewed residents regarding the cholera epidemic, attempting to ascertain how many people had been symptomatic and how many had died from the disease.

4. Which is not to say that epidemiology is unitary and homogeneous or that it cannot provide tools for countering official erasures. An “epidemiology without numbers” (Almeida Filho 1989) and “critical epidemiology” (see Breilh 2003) provide examples of how Latin American epidemiologists have pioneered techniques for revealing social inequality and structural violence.

5. Following adoption of the 1999 Bolivarian Constitution, the MSAS became the Ministerio de Salud y Desarrollo Social (Ministry of Health and Social Development).

6. Marilyn Nations and Cristina Monte (1996) and Rudi Collorodo-Mansfeld (1998) document, respectively, the way that the Brazilian and Ecuadorian states also placed cholera within a geography of blame and efforts on the part of people stigmatized by the health education program to resist denigrating stereotypes.

7. I interviewed Cardenas in Tucupita on March 29, 1995.

8. Marcos Cueto (1997:208) reports that the Persian Gulf War also appeared in Peruvian accounts of the cholera epidemic.

9. I discuss Gómez, his dance troupe, and this performance elsewhere (Briggs 1996). See Guss 2000 and Salas 2003 on the way that performances of race, culture, and tradition advance corporate and state agendas in Venezuela.

10. Farmer (1999) has made the same observation with respect to the relationship between Haitian vernacular healing and biomedical treatment.

11. I ask readers to keep in mind that when the term *premodern(s)* appears in subsequent discussion I am referring to Latour’s construct, not to a bounded type of societies that are distinguished from “modern” ones.

12. Warner’s essay is, of course, part of a much larger discussion of public spheres, public cultures, and counterpublics. For examples, see Calhoun 1992 and Gaonkar and Lee 2002.

13. Janelle Taylor (2003) warns that the most gripping narratives of medical pluralism can reify culture in ways that create social distance and assert the superiority of biomedical perspectives.

14. Stacy Pigg (2001) similarly shows how texts used for HIV/AIDS education in Nepal were ranked in terms of their provenience, lexical register, and degree of detail, thereby creating hierarchies of audiences and knowledges.

15. Farmer notes that “conspiracy theories have been a part of the AIDS scene since the advent of the syndrome” (1992:230). See Epstein 1996, Fine 1992, Kane 1998, Turner 1993, and Treichler 1989 on the role of conspiracy theories—and their dismissal—in shaping discourse about the HIV/AIDS epidemic in the United States.

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