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SICKNESS, VIOLENCE AND RECONCILIATION:

CONGENITAL HEART DISEASE IN IRAQ

An Honors Thesis

Submitted in Partial Fulfillment of the

Requirements for Graduation with

Undergraduate Research Honors

Georgia State University

2011

by

D. Alexander Phillips

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Date

SICKNESS, VIOLENCE AND RECONCILIATION:

CONGENITAL HEART DISEASE IN IRAQ

by

D. ALEXANDER PHILLIPS

Under the Direction of Dr. Cassandra White

ABSTRACT

Congenital heart disease affects tens of thousands of children and families throughout Iraq, where complex surgical treatment remains largely unavailable. Through participant-observation and in-depth interviews, I investigated the understandings of this disorder among families in two areas: Kurdish northern Iraq and Arab southern Iraq. I pay particular attention to families' perspectives on causes and treatment of the disorder in relation to historical and current macrosocial forces. Among the families I spoke with, there is a strong connection between the recent history of violence in Iraq and congenital heart disease. This thesis is largely an attempt to understand the uses and implications of this connection between sickness and violence for Iraqi families pursuing treatment through an international non-governmental organization.

INDEX WORDS: Congenital heart disease, Birth defects, Iraq, Violence, Reconciliation, Kurdistan, Transnational medicine

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An Honors Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

Bachelor of Science

in the College of Arts and Sciences

Georgia State University

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Georgia State University
December 2011

DEDICATION

Yahya Omar was the first child I actually knew to lose his life to congenital heart disease—the first, for me, to put a face to the issue. I feel humbled to dedicate this paper to him and his family; I am sorry I do not yet have more to offer.

ACKNOWLEDGEMENTS

Many kind and patient individuals have aided me in both researching and writing the material presented here. Most importantly, and spanning both groups, is Dr. Cassandra White, whose brilliant guidance has been essential to every phase of this project—from design to research to writing and presentation, and anything in-between. I consider myself extremely fortunate to have been introduced to her, and thank Dr. Jeffrey Glover for that privilege, as well for sparking my interest in anthropology.

On the writing side, thanks are due first to Micah Hughes, whose intellectual (and often not-so-intellectual) friendship has influenced and, I think, greatly improved this thesis—as well as many other aspects of my life. Thanks also to Brian Adams and Jeremy Courtney for comments on earlier material included here.

The list of those essential to my two summers of research is extensive. I would never have made it to Iraq without Jeremy and Jessica Courtney, Ben Landis, and my supportive parents, siblings, and friends. The welcome I have felt all over Kurdistan and Iraq was first extended to me by Dr. Aso Faiq Salih, who was also one of the first physicians to truly inspire me. None of the work I was lucky to be a part of with the Preemptive Love Coalition would be possible without Awara Hassan Mama, I thank him for his dedication to service and for welcoming me as a brother. Thanks are due also to Cody and Michelle Fisher, Dr. Ahmed and Dr. Hussein, Knar, Dr. Nadine Sinno for help with written Arabic translation, David and Willie, Matt and Cayla Willingham, the PLC interns, and especially to Lydia Bullock for her support and continual inspiration. Finally, I thank all of the families affected by congenital heart disease in Iraq who were willing to allow a stranger into such an important part of their lives.

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Introduction and Methods

> "They've dealt with war and violence for so long that you—sometimes you have to cut your losses, and when it's something like congenital heart disease—maybe with that child you have to cut your losses."
>
> -Patrick, a medical aid worker in southern Iraq

The classification congenital heart disease (CHD) comprises the most common birth defects in the world—birth defects of the heart. Reported incidence varies based on what defects are included, but a common estimate is that about one in one hundred children born worldwide are expected to have CHD (see Bernier et al. 2010). Congenital heart disease is a serious and understudied public health problem in Iraq, where tens of thousands of children are on waiting lists for surgery and thousands more are born with the disease each year.

Except for a small proportion of simple and self-correcting defects, and some defects that can be repaired through minimally-invasive procedures, most cases of symptomatic CHD—especially those that consist of large, complex, or multiple defects—require open-heart surgery if the child is to survive into adulthood. When I began field research in Iraq in the summer of 2010, these open-heart procedures were not being performed regularly in the country due primarily to a lack of surgeons, nurses, and other health workers trained in the specialty, as well as to a lack of infrastructure including equipment and facilities for performing these difficult surgeries. For families of children who had severe cases of CHD, the only option was often treatment outside of the country. This dependence on treatment abroad was still the norm when I returned for a second summer of fieldwork in 2011, although another option had begun to emerge.

In August of 2010, shortly after I returned to the United States, a medical non-governmental organization (NGO) that I had been volunteering with, and that had previously been facilitating treatment abroad for children with CHD, brought an international medical team

to a city in northern (Kurdish) Iraq where surgeries were performed in-country and local physicians, nurses, and technicians were trained. This model of training missions that bring foreign teams to Iraq to treat children in-country while also teaching local healthcare providers has become the primary program for this NGO in two cities in Iraq: Sulaymaniyah, a mostly Sorani Kurdish-speaking regional center in northern Iraq (Iraqi Kurdistan), and Nasiriyah, an Arabic-speaking and predominantly Shia city west of Basra in southern Iraq.

These two sites—one in Kurdish northern Iraq and one in Arab southern Iraq—were the primary locations of my fieldwork. I also traveled with a group of parent-child couples and members of an NGO to Istanbul in 2010, before the in-country training missions had begun. But before discussing the methodology and frame of analysis employed at these different sites or the results generated and the conclusions drawn from them, I want to provide a brief historical context so that when my argument refers to Iraq's "history of violence" I will be employing a concept that is slightly more concrete. Understanding the "war and violence" that Patrick[1] referred to in the quote that began this section is necessary to both an epidemiological and an anthropological understanding of congenital heart disease in Iraq—though it is primarily the latter with which this study is concerned.

Setting

There is a danger in representing selective histories—for example, a history of violence—in that by excluding certain topics from that history we may also miss how those topics considered to be "outside" the frame of discussion influence and are influenced by whatever is considered to be "inside" the frame. So that, in a history of violence that privileges political violence (which most histories of this type tend to do), we may miss the "continuum of

violence" (Bourgois 2004, Scheper-Hughes and Bourgois 2004:5) that includes not just political but also structural, symbolic, and everyday violence, and how this continuum is influenced by or influences aspects of life from religion to children's games to arts, as well as other everyday conditions of living. Because of this danger, I want to emphasize that this account is in no way a definitive, comprehensive, or robust cataloging of violence in Iraq—it is simply a collection of some violent events that I believe are important in discussing congenital heart disease in northern and southern Iraq.

It is essential to note that different groups in Iraq have suffered for different reasons at different times. A common way to delineate the different populations of Iraq is to talk about the Kurds in the north, Shia Arabs in the south, and Sunni Arabs in the center and west. This delineation of course leaves out other minorities like Turkmen, some Christian sects, and Faili Kurds to name a few, does not address political and linguistic differences in major Kurdish regional constituencies, and does not account for geographical overlap or highly pluralistic areas such as Baghdad. But given the fact that most of my informants fall into one of these three broad categories, it is a good enough starting point.

The first city I worked in, Sulaymaniyah, is a large city in northeastern Iraq and capital of the As-Sulaymaniyah governorate in the Kurdish Autonomous region. Also within the As-Sulaymaniyah governorate are the villages of Said Sadiq and Chamchamal, where some of my fieldwork took place. The Kurdistan region, which includes the governorates of Dohuk, Erbil, and As-Sulaymaniyah, functions autonomously and is administered by the Kurdistan Regional Government (KRG). The Kurds of northern Iraq were first promised autonomy by the Iraqi government in 1970 but the agreement was never implemented and eventually broken. In response, the Kurds, led by Mustafa Barzani, continued an ongoing revolt against Iraq with the

support of Iran, while Tehran and Baghdad were embroiled in a border dispute centering on the Shatt al-Arab/Arvand Rud (Hilterman 2008:7). The border dispute and, effectively, the Kurdish revolt ended with the Algiers Agreement of 1975 that favored Iran's territorial claims in exchange for their withdrawal of support for the Kurdish insurgency (Bayat 2008:33).

Following Iraq's success controlling the 1970s insurgency, the Kurdistan Democratic Party (KDP) split along the long-standing division between Barzani and his Kurmanji-speaking allies of northern Iraqi Kurdistan and the primarily Sorani-speaking "southern Kurds." This latter group formed the Patriotic Union of Kurdistan (PUK) under the leadership of Jalal Talabani (currently the president of Iraq), while Barzani's sons retained control of the KDP (Bruinessen 1994). The next major tragedy in Kurdish history resulted from the alliance of the Iraqi Kurds (first the KDP, followed by the PUK) with Iran during the Iran-Iraq war. Hilterman describes the violence consequences of this alliance:

> The response [of the Iraqi government] was ferocious. In an escalating counter-insurgency campaign, the regime began destroying Kurdish villages on a massive scale in 1987, using chemical weapons to kill insurgents and scare the population. The next year saw the culmination of this strategy with the gas attack on the town of Halabja that killed thousands, followed by the Anfal campaign in which the regime used gas to flush villagers out of the countryside. [2008:7]

The Kurdish movement did not recover from the Iran-Iraq war and Al-Anfal campaign until Iraq's invasion of Kuwait and the resultant Persian Gulf War, when, with strong encouragement and a guarantee of support from the United States, the Kurds in the north, as well as Shia Arabs in the south, revolted against the Ba'athist regime. However, like many of the Kurds' allies before them, the United States did not follow through on their promise of support and Baghdad crushed the revolts (Gordon 2010:15-16; Hilterman 2008:8). Instead, the U.S.

continued with a policy of comprehensive sanctions against Iraq, which were originally passed by the UN Security Council in 1990 and justified as a non-violent way of dealing with Hussein's regime and its many human-rights violations. Unfortunately, as Gordon (2010) has shown, the effects of the largely U.S.-controlled UN sanctions were quite violent and, following the destruction of much of Iraq's infrastructure during the bombing campaign in 1991, a humanitarian disaster for all Iraqis (see also Bennis and Halliday 2000; Pellet 2000; WHO 1996).

The sanctions regime remained in place until the U.S.-led invasion of 2003, at which point there was a break in violence dealt to Kurds and the beginning of a period of some growth and stability in the three governorates of the Kurdish region. Not so for the rest of Iraq. Shia Arabs in the south have shared with the Kurds in suffering the devastating effects of the sanctions regime, as well as Ba'athist policies of exclusion from things like medical services, funding and supplies, and direct violence such as disappearances, mass displacements and killings of Shias and the destruction of much of the wetland environment that is home to marsh Arabs in southern Iraq. However, unlike the Kurds, Iraqis in the south also suffered much more of the direct effects of the Persian Gulf War, the 2003 Iraq War, and the continuing occupation of Iraq. Nasiriyah was a location of bombardment and fighting in the wars and occupation, and scars of these conflicts remain in the memories of residents, in bombed-out vehicles and tanks on roadsides, in defunct or slowly rebuilding medical systems.

Direct sectarian conflict has led to much suffering for both Shia and Sunni Arabs. Sunnis have also suffered from the structural violence of withheld supplies, funding and services after Shia Arabs claimed positions of power following the fall of Saddam Hussein's government in 2003, mirroring the similar suffering of Shias at the hands of the Ba'athist regime (note that although the Ba'athist regime was tied to the Sunni minority, and that "Sunnis" in a general

sense may have suffered less under its rule, the regime itself was a secularizing, nationalist party that is not a simple outgrowth or pure representation of the Sunni minority). Though it is important not to conflate or confuse suffering of Sunnis with the mass destruction of Shia and Kurdish lives and life-ways in the recent history of Iraq, the Sunni minority has also, like Shias, suffered the direct effects of warfare, and, like both Shias and Kurds, much of its indirect effects.

The importance of Western—primarily U.S. and to a lesser extent British and other European states—involvement and interests in the history of violence of Iraq is difficult to overstate. Recently this involvement includes the initial and arbitrary European-controlled drawing of the borders of Iraq[2] and its neighboring states (out of which has grown violence between Kurds and Turkey, Iran, Iraq, and Syria, the countries between which they found themselves divided). It also importantly consists of the United States' support of Saddam Hussein as a critical ally against Iran (in the face of human rights violations), the provision by European and American companies and investors of the chemicals, technology, and financing necessary to create the chemical weapons used by the Ba'athist regime against Kurdish and Shia populations (as well as Iran), the Persian Gulf War and its associated bombing campaigns and introduction of depleted uranium weapons into Iraq, the encouraged-but-not-supported Shia Intifada and Kurdish uprising in 1991, the brutal sanctions regime, and finally the 2003 Iraq war and continuing occupation. I do not re-emphasize this Western involvement as a polemic, but as a historical relationship that is essential to understanding what my informants had to say about congenital heart disease.

In 2010, when I began my fieldwork in Sulaymaniyah, the Kurdish Region had been enjoying relative stability for nearly seven years. In 2011, when I first went to Nasiriyah, the Shias of southern Iraq had just begun to experience some stability as well—at least compared to

the last few decades in Iraq. The difference between these two cities is pronounced, the fact that Sulaymaniyah has enjoyed more autonomy, more investment, and more stability for more time than Nasiriyah is evident to any person that has visited both places. These differences duly noted, the need for treatment for congenital heart disease is great in both places, as it is in all of Iraq. The reasons for this should not be difficult to determine after understanding Iraq's violent (modern) history.

Congenital Heart Disease in Iraq

In epidemiology, the prevalence of a disease, or its overall burden, is understood to be influenced by multiple factors ranging from its incidence, or rate per number of people per unit time (or, for CHD, per number of births), to its natural course—whether it resolves or kills slowly, or resolves or kills quickly—and finally, what level of (and for whom) treatment is available (see Centers for Disease Control and Prevention 2010:3.16-3.18). While congenital heart disease can kill quickly—whether shortly after birth or in an unexpected heart failure later—it is for the most part a disease with a long course (Hoffman et al. 2004). Children can have very particular and specific windows within which they may be operated on safely, or may become increasingly urgent at particular stages of growth—but they often can live with CHD (with diminished ability to run and play with friends, less energy and focus for studies, pains, reduced chance to marry, and other effects) for many years. This long course is then combined with a nearly absolute lack of treatment—due especially to the past 30 years of violence in which (instead of 30 years of advancement) Iraq's medical infrastructure and capability was reduced from competitive levels in the 1980s to nearly nonexistent in many areas by the 1990s and early 2000s. And even where it did exist in some form, as Patrick noted, "when it's something like

congenital heart disease—maybe with that child you have to cut your losses." Assuming that the incidence of CHD in Iraq is similar to what it is worldwide—about one in one hundred—these factors (long disease course combined with lack of treatment) easily demonstrate why tens of thousands of kids are in line and on waiting lists for surgery.

There is also the hypothesis (and many anecdotal reports claiming) that the incidence of CHD in Iraq, or in some areas of Iraq, may be higher than global or regional averages. Some of the more common theories on cause of increased incidence (in academic and epidemiology literature) include consanguinity (e.g. Becker et al. 2001, Bittles 2003), sanctions-induced malnutrition in mothers (see Bennis and Halliday 2000 for the link between sanctions and malnutrition and Botto et al. 2003 for the link between malnutrition and CHD), and chemical weapons—including depleted uranium weapons used by the U.S. and allies and various chemical agents like VX and Mustard Gas used by the Ba'ath party (e.g. Abu-Qare et al. 2002, Abolghasemi et al. 2010). Given the link between unequal relations of power and social/medical sciences, it is not surprising that the first area of inquiry (intra-family marriage) seems to be generating the most interest (especially among Western researchers), followed by some work on the second and less on the third. One compelling, if anecdotal, argument for the link between violence and *incidence* of CHD are the accounts of residents as well as others familiar with the area that many women and families in Fallujah—a town west of Baghdad where some of the most brutal fighting of 2003 and 2004 took place—have simply stopped having children. Many report that so many children are being born with birth defects that women are afraid to get pregnant. In a society that generally values the production of offspring this account is alarming to say the least. Fallujah and the areas around it remain somewhat more volatile than either of the cities in which I worked, and consequently there is less investigation into verifying rates or

identifying causes of these disorders (but see Alaani et al. 2011a, Alaani et al. 2011b, Busby et al. 2010).

Methods

Following these admittedly limited (and selective) accounts of Iraq's history of violence, as well as congenital heart disease in the country (and an *epidemiological* understanding of links between the two), a better idea can be formed of the setting I entered into to conduct fieldwork in hopes of obtaining an *anthropological* understanding of congenital heart disease and its links to Iraq's history of violence.

In order to accomplish these goals, I conducted five months of fieldwork in Iraq split over the summers of 2010 and 2011. I received IRB approval for this research from Georgia State University in 2010, and submitted an extension that was approved for research in 2011. In 2010 I worked primarily in the city of Sulaymaniyah and the nearby village of Said Sadiq, as well as in Istanbul, Turkey. In 2011 I had the opportunity to expand my research to include the Shia Arab city of Nasiriyah in southern Iraq, as well as continue research in Sulaymaniyah and another nearby village—Chamchamal.

I spent time with patients and their families in hospitals and the offices of local cardiologists in Sulaymaniyah and Nasiriyah—including spending many hours a day for weeks at a time at a hospital in Nasiriyah with families who had come to stay while waiting for the hoped-for treatment of their child. Additionally, I observed and sometimes participated in interactions with families of patients in the offices of an NGO that was helping, in 2010, to send children abroad for surgery, and in late 2010 and 2011, to bring in medical training teams to provide surgery and training in-country. I traveled to homes in Sulaymaniyah, Said Sadiq, and

Chamchamal to talk with affected families about Iraq, Iraqi Kurdistan and congenital heart disease. At the end of the summer of 2010, I traveled with three patients, each accompanied by one parent and some of the members of the sending NGO, to Istanbul to observe directly the process of traveling abroad for surgery.

In the conduct of this participant-observation in northern (Kurdish) Iraq, southern (Shia Arab) Iraq, and Istanbul, Turkey, I conducted a number of informal interviews, which largely consist of normal but intentional conversation with note-taking and "are a side benefit of participant observation" (Hahn and Inhorn 2009:21).

In addition to this participant-observation and associated informal interviews, I conducted 23 formal, semi-structured interviews in Nasiriyah, Sulaymaniyah, and Said-Sadiq. Semi-structured interviews make use of a prepared interview schedule that contains both open-ended and close-ended questions, are "one of the most common forms of interviews used in the anthropology of public health problems" and are "particularly useful when there are time constraints on the interview, when there may not be subsequent opportunities for interviews," when interviews must "collect comparable information," and "for determining *patterns* of knowledge and belief" (Hahn and Inhorn 2009:22; see also Bernard 2011:157-158). Local translators aided me in my interviews (except when the participant felt comfortable speaking English) and I enrolled a total of 26 participants (3 interviews involved 2 individuals). The majority of my interviews were with parents and families, but most individuals involved in the treatment of CHD in Iraq were represented, including local medical workers, foreign medical workers, foreign Aid/NGO workers, fathers, mothers, uncles, and two previous patients themselves—one female and one male patient who were old enough to be interviewed. Medical workers included technicians and nurses in addition to physicians, and families represented

included both those who had traveled outside of the country for surgery and those that were able to receive it in one of the medical training missions within Iraq. Local participants were predominantly (Sunni) Kurds and Shia Arabs, but Sunni Arabs and Yezidi Kurds were also represented.

This limited historical, epidemiological and methodological foundation is important in revealing links between violent histories and current illnesses, and is essential to the anthropological argument I wish to develop. Equally important, and to which I now turn, is a theoretical background and definition of the terms used and subject examined.

I. Sickness

> "My parents, my grandfathers and mothers, they were all strong and lived long lives. So why do I have a child like this?"
>
> -Fatima, mother of a three year-old girl with CHD, southern Iraq.

The subject of this study is reflected in the title: the *sickness* of congenital heart disease in Iraq, and specifically its relation to and interaction with violence and reconciliation. I use the definition of sickness laid out by Arthur Kleinman: "sickness [is] the understanding of a disorder in its generic sense across a population in relation to macrosocial (economic, political, institutional) forces" (1988:6). Although there has been opposition to defining the term illness in ways not traditionally recognized by both patients and physicians (see Flegel 2010), a critique that could as easily be oriented to Kleinman's definition of sickness, I do not see the use in inventing a new term for use in academic literature when one has already been articulated in a seminal and widely-read work of medical anthropology (i.e. Kleinman 1988).

Sickness is an analytic construct describing broad understandings, and in order to examine it I chose to explore "community (sickness) perspectives" rather than "(individual) illness narratives." To draw a loose analogy: community perspectives are to sickness as individual narratives are to illness (although it may be more accurate to understand sickness as one particular facet of illness, and community perspectives as one component contained within the illness narrative).[3]

Sickness is defined as a conceptualization or a concept-in-use ("the understanding of a disorder…"), and important aspects of this concept-in-use may be found within the answers about the disorder that affected individuals, families, and groups have accepted. Kleinman (1988:29) has shown that illness (and by extension, sickness) "raises two fundamental questions for the sick person and the social group: Why me? [And] what can be done?" For individuals, answers to the first question are often termed explanatory models—answers to the second, treatment-seeking behavior. For sickness, however, the answers to these two fundamental questions lie in community perspectives on cause and community perspectives on treatment (Phillips 2011).

Kleinman's fundamental questions are reflected in Fatima's words at the opening of this section—a mother asking "why me" while seeking treatment for her daughter during an international medical training mission (one of the only things that "can be done"). It is this line of questioning that guides my exploration of the sickness CHD in Iraq (the broad understanding of CHD among groups in Iraq in relation to social forces and its use as a concept by those experiencing it). I am not interested in *interpreting* sickness or uncovering its "essence"—instead, I am hoping to get at an understanding of sickness (or to get at the meaning of sickness) in more of a Wittgensteinian sense, namely, what does the sickness CHD in Iraq *do*?[4] Or, what is

the use of broad understandings of CHD in Iraq in response to macrosocial forces for those individuals (affected families, physicians, aid workers or others) that employ such concepts? Because the majority of my interviews were with affected families, their use of sickness is more prominent in this paper than that of health or aid workers.

This specific focus on sickness and the structure of my research question and methodology was determined in part by designing around limitations and opportunities: I had the opportunity to work in both Iraqi Kurdistan and southern Iraq with families affected by CHD, but I was limited in both language skills and research experience. This led to my desire to focus on sickness rather than "illness," which as a concept encompasses much more. An inquiry into sickness alone would not necessitate going to as great a depth with each individual informant—a depth of understanding I did not feel I could adequately reach with the aid of a translator (though these and other concerns may still exist with the anthropologist as translator—see Asad 1986a) and limited research experience.

Whenever I use the word sickness in this paper I am referring specifically to this concept and to the questions it carries with it. What is the use of the concept of sickness for those employing it? What can exploring answers to the "fundamental questions" raised by sickness tell us about its meaning (i.e. how it is used)? If sickness is an understanding of a disease in relation to economic, political, and institutional macrosocial forces, and if it can be "gotten at" through questions of cause and treatment, then what specific forms of these different macrosocial forces are implicated in understandings of cause and treatment of CHD in Iraq?

II. Sickness and Violence

> "Don't you think war, this environment we live in, after the wars, and wars, and wars in Iraq, is causing this problem?"
>
> -Bayda, mother of a three-and-a-half year-old girl with CHD, southern Iraq.

Unquestionably, the "macrosocial force" most implicated in community perspectives on both cause and treatment of CHD among the families I spoke with in Iraq is violence. I want to deal here first with violence and cause, and return to violence and treatment later. Bayda's account is as representative as it is gripping. In fact, in discussing etiology (causality) in my 23 formal interviews, some form of violence was mentioned in 18 of them (when only interviews with local residents of Iraq are considered, this changes to 16 out of 19).

The forms of violence varied both between and within the two regions. Kurds most often cited the chemical attacks and warfare they had suffered at the hands of the Ba'athists (e.g. "before the [Iran-Iraq] war, there was five percent as much CHD as there is now," or "because of the situation after the chemical attacks"), while Arabs mostly talked about the suffering and warfare they had experienced due to American military action (e.g. "because of the war there is so much heart disease," or "the reason is the war").

I found it especially interesting that violence was not only the macrosocial force most discussed in relation to etiology, but that all forms of macrosocial forces that Kleinman identified—economic, political, institutional—were explicitly discussed by my informants *as violence*. Take, for example, what Dr. Ali, a perfusionist and anesthesiologist from Nasiriyah, had to say about the topic of cause:

> In my idea, it's because of many factors. The most important one is the many wars that have happened in Iraq, especially the south of Iraq. The malnutrition of pregnant women during the period of blockade for

> about 13 years—the sanctions caused malnutrition for the girls, and that caused congenital heart defects in their babies. Also, the use of illegal weapons and radiation in the south of Iraq during 1991 and 2003. During 2003 when the USA and international forces attacked Iraq they used an illegal weapon—[depleted] uranium. This is confirmed by identification here—especially in Nasiriyah—it's confirmed that there is uranium…. Iraq in general, and the south, especially, was deprived during the Saddam period. Because most of the people here worked against Saddam and against the government at that time. So the deprivation from health services was a part of the punishment that the Baath regime followed.

All of the macrosocial forces Kleinman mentioned are present in this single account as forms of violence—the economic violence of sanctions, the political violence of warfare and chemical weapons, the institutional violence of denied support and access to health services. On the last point consider also the words of Zaineb, 30 year-old mother, in response to the question of cause (Why us?): "because in the time of Saddam there were no medicines."

These accounts duly noted, the most common reasons given were political and outright violence, and sometimes simply "war." I asked Omar, a Sunni Arab and father from Fallujah, why he thought many children had CHD in Iraq. "The reason is the war with America," he said, before asserting, "most Iraqis think the same. Not even most, *every* person thinks this." I had a similar interaction with a 56 year-old father of 16 (including a seven year-old boy with CHD): "the reason is the war, depleted uranium and things like this…. Most people think that."

I was aware during my interviews that, despite the IRB-approved consent procedure's guarantees of confidentiality, many informants might be reluctant to tell an American that they believed America was responsible for their child's problem all the while hoping for treatment from an American-led medical team. Judging by the responses I received, I overestimated this

reluctance—but if there is error in the sample, it would seem to be in favor of *more* families linking (American) violence to sickness. I did receive a few non-answers or evasions of the question ("I'm not sure, that's a doctor's question") the most obvious and likely reason being the informant simply was not sure, though it is also possible that my lack of research experience and skill in gaining the trust of my informants was to blame. Near the end of my fieldwork in 2011, I began using a follow-up question on the few occasions that an informant would seem to be uncomfortable when I asked about *their* idea of general causality—I would ask instead what they thought *other people* in their community[5] thought about cause. It was this formula that elicited Bayda's somewhat incredulous remark that I opened this section with:

> D.A.P.: Why do you think many children have CHD in Iraq?
> Bayda: When we learned about this problem with [my daughter] they told us that because me and my husband are relatives, cousins, we have this problem. Is this true?
> D.A.P.: Did the doctor tell you that?
> Bayda: Yes, the doctors.
> D.A.P.: From talking with others, what do a lot of people think causes this problem?
> Bayda (after a short pause): Don't you think war, this environment we live in, after the wars, and wars, and wars in Iraq, is causing this problem?

Similarly, I asked the Uncle of a young girl with CHD (her father left her mother when the defect was diagnosed) what he thought about cause, and after saying he didn't "have an answer to that question" I asked him if he had spoken to others who had any thoughts on the reasons for so many heart problems—to which he replied "many people say that the reason is the war, that has an influence on the high rate of heart problems."

There were a few other topics mentioned when I discussed cause with local informants—these included poor prenatal care and poverty (which many anthropologists would label structural violence), consanguinity, expired food ("other countries are sending us expired food"), as well as some less-direct effects of violence like flight and grief caused by warfare. However, none of these accounts were mentioned by more than a few informants each, and many were secondary to some type of direct violence as etiologic agent.[6]

These accounts clearly link violence and sickness for these families in Iraq, but they bring us only partway to the meaning of the sickness CHD—which I take to lie in its use. My informants have, I believe, answered the question I posed earlier on what specific forms of Kleinman's "macrosocial forces" are implicated in the first of his two "fundamental questions." To continue from this link to an understanding of the use of sickness for these families, I find much recent (and some less recent but well received) anthropological and critical theory on and around violence useful.

In her article on "displacing violence" in postwar Sierra Leone, Rosalind Shaw has recently described the use of plays and stories depicting spiritual warfare as a way of re-narrating and re-imagining past conflict and political warfare for Pentecostal youth in Sierra Leone (Shaw 2007). However, unlike the families in Iraq that I spoke with, who would describe directly instances of past violence, for Sierra Leonean youth these stories of spiritual warfare also offer a way to narrate past conflict without directly referring to or describing Sierra Leone's civil war. One reason for this difference might be that the past aggressors for my informants were not neighbors and members of the community but more "distant" oppressors like Saddam Hussein, Ali Hassan al-Majid ("Chemical Ali"), the Ba'ath Party, Turks or Turkey, or the Iraqi

government (for Kurds)—or the United States, Britain and their allies, Iran, the Ba'ath Party, or Saddam Hussein (for Arabs in the south of Iraq).

But despite this difference, the incorporation of past political violence into community perspectives on cause of CHD can be seen as fulfilling one of the same goals (or uses) of stories of spiritual warfare among Pentecostals in Sierra Leone: that of displacing violence and "re-membering" and narrating past conflict (Shaw 2007:68). This concept articulates well with other discursive strategies that have been employed in the aftermath of political violence for similar uses—to selectively memorialize and forget (Gusterson 2007:160), to interact with, to make sense of, and/or to remember or forget in new ways, past violence (see for example Warren 1993, Sturken 1997, Yoneyama 1999, Das et al. 2001, Perera 2001, Jackson 2002).

But I believe that the sickness CHD—which we have seen specifically links past violence with congenital heart disease—serves another (additional) purpose for families in Iraq, similar to the first in that it is in a way a mirror image of it. Explorations of two parallel concepts are helpful here: horror and pain/suffering. I mean something very specific by *parallel* concepts. I do not mean that horror and pain/suffering are interchangeable, nor that they necessarily overlap, but that each one moves towards its effects in a similar fashion. It is in this movement that a second use of the causal aspect of sickness emerges in both.

Talal Asad's final chapter to his 2007 book *On Suicide Bombing* attempts to explain the reactions of horror among people in the West to suicide terrorism, especially in light of a lack of such reactions of horror to the multitude and variety of "unimaginable cruelties perpetrated in secret or openly" by many different groups, actors, or institutions that are all evident in the world today (Asad 2007:65). Asad pauses on the way to addressing this specific question to take up the idea of horror itself ("But first: What is horror?") and it is this part of his book that I think is

helpful in understanding the use of the sickness CHD in Iraq. Asad tells us "horror is not a motive but a state of being...horror has no object. It is intransitive" (68). Following Cavell 1999, Asad stresses that "horror applies not only to the perception that *our own* identities are precarious but also those of other humans—and not only the identity of individual humans but also that of human ways of life…. Horror is a state of being that is *felt.* Horror explodes the imaginary, the space within which the flexible persona demonstrates to itself its identity" (Asad 2007:68, emphasis in original).

One may recognize some similarities between the effects of horror that Asad describes here and the effect of pain and suffering caused by torture or violence that Elaine Scarry so famously described as an "unmaking of the world" (Scarry 1985). Again, I do not mean to say that "exploding the imaginary" and "unmaking the world" are the same, but there are unmistakable parallels between "horror [as] a state of being that is *felt* [and] explodes the imaginary" and "pain as a state of being that is felt and unmakes the world." It was building upon Scarry's work that Scheper-Hughes and Lock, in a widely-read article in medical anthropology, described the "unmaking of the world in sickness and death," arguing that just as "pain destroys, disassembles, deconstructs the world of the victim...[we] would offer that illness, injury, disability, and death likewise deconstruct the world of the patient *by virtue of their seeming randomness, arbitrariness, and hence their absurdity*" (Scheper-Hughes and Lock 1987:29, emphasis added). The importance of Scheper-Hughes and Lock's conceptual linking of Scarry's "unmaking of the world" to sickness and the project of medical anthropology will be apparent following Asad's analysis of the concept of horror.

After various accounts and depictions of horror and a discussion of others' analyses of them, Asad turns to Georges Franju's 1949 documentary *Blood of the Beasts* about a

slaughterhouse in a Parisian suburb (in which "the studied depiction of industrial death produces an effect of overwhelming horror in most audiences" [Asad 2007:80-81]), and to Adam Lowenstein's analysis of the film:

> "Lowenstein, in a fascinating monograph on horror films, draws on Walter Benjamin's idea of allegory to argue that '*Blood of the Beasts* insists on disclosing connections between everyday life and the horrors of history.' In particular, Lowenstein joins critics who have made the connection between the grim labor of the abattoir and the Holocaust." [81]

But Asad disagrees with Lowenstein's connection: "the experience of horror...does not depend on interpretation, whether allegorical or symbolic. It does not convey meanings: *it is a state of being* (Asad 2007:81, emphasis in original). While Asad recognizes similarities between the Holocaust (specifically Nazi death camps) and the slaughterhouse—including the treatment of holocaust victims as *untermenschen*, as animals—he asserts that the emotional effect of the documentary "does not depend on its being read as a Nazi death camp." Asad's final assertion against this point is particularly relevant to broad understandings of birth defects in Iraq (e.g. the sickness CHD):

> Horror, I want to insist, is essentially not a matter of *interpretation*. When the viewer makes a connection between the abattoir and the death camp, *she has gone some way to mastering horror* and begun to develop an ethical judgment. What I want to say is not that horror is natural (indeed, it is always mediated by sediments and traces that have been inscribed in the body) but that it *requires no discursive effort*. [Asad 2007:81, first emphasis his, the rest mine]

It is here that a second use of the sickness CHD can be grasped. That is, the causal aspect of sickness is a *discursive effort* that makes a connection between past violence and the current

suffering of (perhaps we can even say *horror at*) birth defects in the heart of a child—and in making this connection *goes some way to mastering the felt state of being that is horror or suffering*.

I believe, mostly due to my regrettably large number of experiences in cardiologists' offices when this event has taken place, that parents' "felt state of being" upon hearing that their child has an urgently dangerous hole in her heart that is theoretically easily curable but that this cure is almost certainly unattainable for them—could accurately be described as horror. But I do not want to rest solely on this assumption or on my ability to read into families' bodily and facial reactions a particular state of being. Instead, I will return to the parallels between horror as a felt state of being that explodes the imaginary (Asad following Stanley Cavell) and sickness and suffering as a felt state of being that unmakes the world (Scheper-Hughes and Lock following Elaine Scarry) in order to bolster my argument.

On the one hand, I believe Asad's own expansion of Cavell's description of horror as "the perception of the precariousness of human identity, the perception that it may be lost or invaded, that we may be, or may become, something other than we are, or take ourselves for..." (Cavell 1999:418-419) to include "not only...the perception that *our own* identities are precarious but also those of other humans..." (Asad 2007:68) further supports that these families experience horror at congenital heart defects (and likely even more so for the increasingly visible conditions like neural tube defects and musculoskeletal defects). Because even though Scheper-Hughes' work in Brazil may have complicated the idea of an *unbreakable* bond between mother and child in the face of acute poverty and structural and everyday violence (Scheper-Hughes 1993), we would surely expect that a concern with the precariousness of the identities of other humans

would include our own children, grandchildren, younger siblings, and so on, at least as much as it does anyone else.[7]

On the other hand, though I do believe Asad's formulations of horror and my experiences in doctors' offices when CHD was being diagnosed both support the idea that receiving such a diagnosis along with an explanation of its implications is horrifying, and though I suspect some readers who have children would tend to share in that belief, it is not *necessary* for CHD to produce horror per se for it to serve in this second purpose I have described—that of connecting remembered violence to current suffering and thereby going some way to mastering that suffering. For, as Scheper-Hughes and Lock explained, it is "*by virtue of* their seeming randomness, arbitrariness, and hence their absurdity" that sickness and death, like pain and suffering, are able to unmake worlds (Scheper-Hughes and Lock 1987:29, my emphasis). Thus the second function of sickness for families with children affected by birth defects remains—that of connecting remembered violence to the current suffering of CHD, and thereby undermining its "seeming randomness, arbitrariness, and hence its absurdity" that allows it to unmake worlds. Drawing on the language of Talal Asad, this second use of the sickness CHD is to go "some way to mastering horror," a concept and felt state of being that depends on a lack of interpretation, while in the language of Scarry-via-Scheper-Hughes and Lock, it is to prevent or undue the "unmaking of worlds" that depends on randomness, arbitrariness, absurdity. In either formulation this is accomplished by connecting congenital heart disease to remembered violence, or by adopting a broad understanding of congenital heart disease etiology in relation to the macrosocial forces of economic, political, and/or institutional violence—that is, the causal aspect of the *sickness* CHD.

I said earlier that I was interested in an understanding of sickness in a Wittgensteinian sense, or that its meaning lies in its use as a concept by those employing it. The use of the causal aspect of the sickness CHD in Iraq is a kind of reciprocal displacement or re-membering. Specifically, it serves two mirror functions: to use the suffering or horror of congenital heart disease to displace remembered violence by re-narrating, interacting with, making sense of, interpreting, memorializing, and/or remembering this past violence in relation to CHD, and, reciprocally, to use remembered violence to displace the horror or suffering of congenital heart disease by connecting it to or interpreting it in light of past violence (and thereby "going some way to mastering [its] horror" or undermining the conditions that allow it to "unmake the world").

III. Sickness, Violence and Reconciliation

"Medical anthropologists are privileged...in that their domain includes not only the unmaking of the world in sickness and death, but also the remaking of the world in healing…."

Scheper-Hughes and Lock 1987:29

"I think all of the families, all of the patients go home and tell stories about this [foreign medical] team. We have to thank God, and thank this team."

-Bayda, mother of a three-and-a-half year-old girl with CHD, southern Iraq.

I draw on Scheper-Hughes and Lock once again in returning to the question of treatment in relation to the sickness CHD—because although the discursive effort of etiologically connecting congenital heart disease to violence may serve to undermine and lessen its "unmaking" effects, there is also, Scheper-Huges and Lock tell us, an opportunity or model for *remaking* worlds unmade by illness simply through the healing of that illness.

Of course, the most obvious use of surgery for any individual family is the repairing of a particular disease state in their child that they understand to be dangerous. But being concerned specifically with the sickness CHD, the question of social relations and forces emerges again in the domain of treatment. For the families I spoke with, the macrosocial force most implicated in treatment is also (remembered) violence—but the relationship is different than it was for cause as presented above—in the case of treatment it is less a "linking" or "re-membering" than it is a juxtaposition.

This is clear when we consider the actual treatment processes for both the Kurds I worked with in 2010 as well as the Kurds and Arabs I worked with in 2011. In 2010, when no viable options for complex open-heart pediatric surgery existed in the country, the NGO I was volunteering with worked to take children abroad where they could be treated. In addition to speaking to many Kurds who had undergone this journey before, my experience traveling with three parent-child couples to Turkey for surgery allowed me to observe the process directly. Given the tenuous, often violent relationship between Turkey and the Kurdish population that has existed in some form since the drawing of the modern nation-state boundaries of that region, one would not be surprised at some trepidation on the part of Kurds in handing their children over to be literally cut open by a group of Turks. Take for instance the Kurdish father who begged the director of the NGO to arrange surgery with "anyone but the Turks." The NGO explored other options, but still told the father Turkey was the only place they could take his daughter for two reasons: one, there was simply no other option that was financially close to the subsidized treatment the family could receive at the new Johns-Hopkins affiliated hospital in Istanbul, and two, as both a medical *and* a peacemaking organization, it fit the values of the NGO to facilitate some form of dialogue between Turks and Kurds.

Other responses from my interviews displayed, if not fear, at least skepticism and hesitation about their children being treated in Turkey. When I asked Nîgaar, a 45-year-old Kurdish mother, about the difficulties of "going to and getting treatment in Turkey," she told me "I had no hope; no belief that [my daughter] would get good treatment. I just thought that she would die." I asked another mother the same question, to which she replied that the most difficult parts were "A foreign language. Their culture. It was hardest when they took [my child] into the operating room."

I witnessed an incredibly moving example of this last difficulty in the hospital in Istanbul. Novîn, a beautiful eight-year-old girl, and her doting father, Haydar, were sitting in their private room in the newly-built Turkish hospital where, following a very difficult journey from Sulaymaniyah, they had spent the last two days waiting to hear when her surgery would take place. Unannounced, the head surgeon, some of his team, a legal representative from the hospital, the director of the NGO, and a Kurdish employee of the NGO descended on the crisp, sterile little room. In the span of ten minutes the head surgeon quickly explained, with the Kurdish employee translating, that they were ready to take Novîn into surgery and what risks the procedure entailed. Although the purpose of the meeting was to inform and gain consent from Haydar, he seemed almost a spectator to the process, occasionally furrowing his brow and nodding his head to the rapid-fire translation. Twenty minutes after Novîn and her father had been sitting quietly in her room waiting to find out when her surgery would take place, Turkish nurses were entering and sedating Novîn. Haydar quietly looked on while his daughter bawled loudly. Minutes later I watched Haydar, tears flowing down his face, try to keep pace as his daughter was wheeled down the hospital corridor toward the operating theatre, eventually being

blocked off by a Turkish nurse explaining to him, in a language he cannot understand, that he could not follow his daughter any further.

One would imagine offering a child up for open-heart surgery is difficult enough without the fact that those providing the treatment speak a different language and are citizens of a state currently in conflict with other members of your own ethnic group.[8] This difficult juxtaposition of violence/aggression and treatment was also present, perhaps even more so, in the in-country training missions that were being conducted during my second stay in 2011. In these instances other major contemporary conflicts—those between the United States and its allies and Iraq—were brought to the fore when Iraqi families sought treatment at the hands of a medical team that was both U.S.-led and made up largely of Americans and Brits, as well as other Westerners. International conflict was not the only kind salient to these encounters—Sunni Arabs and Kurds traveled to a Shia Arab city for treatment during a program held there, while Arabs traveled to Iraqi Kurdistan when the training and treatment was occurring in Sulaymaniyah.

In all (Turks treating Kurds, American-led Westerners treating Iraqis, Shias treating Sunnis, Kurds treating Arabs, etc.) of these instances there seems to be a similar, and perhaps predictable, outcome. When remembered or even current violence and perceptions of the other as aggressor is placed alongside current treatment wherein these same people work to repair the broken heart of a daughter, son, niece (a problem that, for Iraqis in the south especially, is linked to these groups in the first place), the latter instance of healing and treatment seems to "win out" in representations of that group later on. This transition is seen in the first case I mentioned: a father began by begging that he and his daughter not be placed in the hands of those *Turks* but returned after the surgery extremely grateful for and praising the efforts of those *Muslims*. To some this shift in prescribed identity may seem subtle, but it is important. The other group is no

longer defined by exclusion and difference but by inclusion and commonality. Some of my other interviews with Kurds displayed a similar gratitude and even surprise with reference both to Turkish healthcare workers and American NGO employees (e.g. "we never expected they would be that good with us").

But, one may object, surely this shift in perception of identity from Turk to Muslim has no analogue when it is Arabs' views of Americans or Westerners? While that may be partly true, some of my informants' words came surprisingly close to revealing one. For instance, as I sat with a 52 year-old colonel in the Iraqi Army next to his four year-old daughter resting in the ICU just after surgery, he expressed gratitude from God: "The people and I, we are very happy to work with this group of foreigners [motioning toward the Australian nurse on the other side of the ICU]. To see them put so much effort into helping my child—this is something which God really appreciates." Even more compelling was the response of Yassin, a father whose seven year-old boy had just received surgery: "I especially want to thank them [the medical team] for their work, they are good people. I hope, God willing, that these people would confess in Islam because they are such good people." And finally, if the shift in the Kurdish father's perception above was important because he described those who treated his child not by differentiating nationality but by an inclusive category of religion, then perhaps the response of an Arab father who described those who treated his child not by differentiating religion but by an inclusive category of humanity is similar: "Outside of religion, in the first place we are all people. On that base, we are thankful for what these people have done."

So what is the use of this encounter, with its ability to remake perceptions? According to both the local governments, which officially describe and represent the program as a "Peace Mission" on documents and in public discourse, and to the NGOs involved, it is peacemaking

and reconciliation. Ideally, this peacemaking is to be spread beyond just the families who are getting treatment when "all of the families, all of the patients go home and tell stories," as Bayda claims. This model, which one of the NGOs involved was able to delineate based in part on some of my research and on their programs with the Iraqi Government and other aid groups, has been described as "reconciliation through healing," and states that "when moms and dads believe their children are dying because of someone else's violence, there is no greater opportunity for reconciliation than through providing the healing that leads to wholeness."[9] These groups hold that solving the problem that Iraqis believe has been caused by Americans/Westerners (birth defects) is a much more effective way to "remake perceptions" and reconcile than trying to argue against the basis of those beliefs.

Though this may appear to be a compelling model for combining peacemaking and medical development, it may strike some as being insufficiently aware of the question of power and the politics of place in an encounter between, for instance, Westerners and Iraqis, that at its core seeks to "remake perceptions." This is an important critique that needs to be thought through and developed.

IV. Violence and Reconciliation

"We are living in times that require an integrated national security program with budgets that fund the full spectrum of national security efforts, including vitally important pre-conflict and post-conflict civilian stabilization programs…."

-Admiral Michael Mullen, chairman of the Joint Chiefs of Staff[10]

"On the logo of USAid, it says 'from the American people,' but our work has to be seen as 'for the American people.' Development is a fundamental part of our national security."

-Dr. Rajiv Shah, head (Administrator) of USAID[11]

Modern liberal-democratic sensibilities may not immediately link arguments for "reconciliation through healing" with efforts for national security, but when pressed many would probably not just accept that they are linked but, like Adm. Mullen or Dr. Shah, take this as further reason to support such a program. But from an anthropological, critical, and/or relativist perspective, this begins to be problematic. This issue is especially salient in this particular case—the position could be staked out that what has happened is, in a relationship of such unequal power (Iraq and the US), one party has not only debilitated, occupied, and attempted to transform the other based on its own image, interests and—perhaps most importantly—abilities, but that this has continued outside of the realm of "warfare" with development that reproduces (and is contingent upon) the same unequal relations of power—that the "remaking of perceptions" that seemed so compelling or sensible a model of peacemaking is only so because it requires those with less ability to act to reconcile themselves to their oppressor.

This argument is not new or unfamiliar. Foucault, in an inversion of Clausewitz's famous aphorism of war as politics by other means, has argued that a way of describing politics, or even peace, is as "war by other means" (Foucault 1980:123-124). Given the position just outlined, recent Western involvement in Iraq, and arguments from the Chair of the Joint Chiefs of Staff

against cutting development or aid funding and those of the head of USAID for "aid as national security," even those that do not accept Foucault's thesis generally may be more compelled to accept it for this particular case of reconciliation and "remaking perceptions." Thus we may find ourselves, as the title of this section suggests, wondering not how to bring about reconciliation as an end to violence, but questioning if (and how/when) reconciliation can be seen *as* violence (or at least as war by another means).

One does not even need to delve into poststructural theory, however, to see this principle alive in the world today. Consider instead a recent report produced by 27-year veteran of the defense intelligence community Mark Silinksy for students and colleagues in the U.S. Army Combined Arms Center's Counterinsurgency (COIN) program, aptly titled "An Irony of War: Human Development as Warfare in Afghanistan" (Silinsky 2010). Silinksy explains "in this 21st Century, many soldiers will still be required to close with and kill the enemy. But, the more potent weapons for defeating insurgents in Afghanistan and in a future insurgency are likely to include agricultural development, an effective health-care system, and education, farms, health clinics, and schools" (Silinksy 2010:2). My point is not to argue against building schools or health-care systems, or even against counterinsurgency, but to question development in a way that is sensitive to the productive (and repressive) effects of power. I also wonder how anthropologists who found themselves adamantly opposed, on the grounds of ethics related to how informant data can be used, to the U.S. Army's Human Terrain System, which sought to embed anthropologists with soldiers in order to provide socio-cultural expertise in the conduct of counterinsurgency campaigns, would react to the U.S. military's understanding, and use, of development *as* warfare and counterinsurgency.

Again, though these sorts of critique are relatively familiar, they are especially problematic for the reconciliation-through-healing model because, if we accept that reconciliation is contingent upon and grounded in relations of power, and thus may become "war by another means," then the more effective the healing of Iraqi children at the hands of US surgeons is at "remaking perceptions" the more effectively it can reproduce those same unequal relations of power.

I believe it would be difficult to find a poststructural (or "post-developmental" for that matter[12]) critique that productively and convincingly deconstructed the stance that it is better for a child's heart to not have any holes in it. But if the only way for those holes to be patched both ignores and reproduces unequal relations of power, do we find ourselves at an impasse? Do we have to simply take a normative, "militant" stance and believe that providing surgery is better than avoiding the reproduction of unequal relations of power (even if those relationships may go on to inscribe their effects in sometimes violent ways on even more bodies)?

I think that instead of either taking a normative stance and only occasionally making relatively harmless nods to critical theory, or being concerned solely with deconstructing and making visible relations of power, we can instead engage and make use of critical theory as well as anthropological research to clarify instances and ways that anthropology may effectively have its "boots on the ground."

V. Reconciliation, Nuance and Power

"We have to differentiate between the people and the government. Doctors are coming from a humanitarian point of view. An American treats an Iraqi, and an Iraqi treats an American from a humanitarian point of view…. There is *no difference* between the American people and the Iraqi people. But on the level of government, there is a clear difference."

-Omar, 41 year-old father from Fallujah

Linder, citing Raymond Williams (1983), explains that "critique has acquired two discernible meanings in English, one indexing fault finding, the other invoking a technique of engagement meant to move forward a practice" (Linder 2004:344). In the latter vein, I believe that we can move forward the relatively common kind of development/aid critique just presented when we complicate both the "perceptions held by Iraqis" on the one hand, and the ways that structures of power act both negatively (repressively) *and* positively (productively) on "perceptions," subjectivities, desires, and so on, on the other.

The shadows of a kind of Orientalist discourse are often seen in totalizing beliefs *about* the beliefs of Iraqis. That is, although perceptions of "us" by "them" are common enough topics for discussion, the sometimes differing and usually nuanced views of history and social forces and relationships held by many of the Iraqis I spoke to are not always evident even in scholarly discourse, much less so in popular journalism. Most of the families I spoke with were quick to identify wars or violence, often specifically of the American variety, as causes for their problems—but some, like Omar, were also quick to draw a separation between what the government of the United States does and what the people of the U.S. believe or do.

Additionally, some who identified wars and their effects as cause also clarified that Iraq hadn't *only* suffered from wars with the United States. So that after Abas, a 52 year-old father from Basra, had told me that he believed war was the cause of widespread birth defects in Iraq,

and possibly after noticing some nonverbal cue from me that this is exactly what I expected to hear, smiled and told me "not just American wars. We've also had war with Iran, you know." Thus among just these two men—one who claims that everyone blames U.S. wars for Iraq, but that "America" is not the same as "Americans," and another who explains that while most people think war (especially with the United States) has caused these problems, there have been other wars in Iraq besides those directly involving the United States—a picture emerges of how blame of the U.S. is not as simple as it may seem and is certainly not just an outgrowth of some embodied clash of civilizations. On the contrary, a man like Omar who is adamantly opposed to the U.S. government may simultaneously be just as strongly in support of "the American people."

Not only are the views of individuals more nuanced and fluid than they may seem at first glance, but perceptions between individuals—sometimes even between members of the same family—can differ substantially. For instance, one Sunni father shared that he had come to receive treatment in a Shia city because he wanted to send a message of peace to both his Sunni community back home and to the Americans and Shias who were "no different" than him. But another member of his family told me that this particular treatment program was simply the best option that was available and that it would have been more difficult to seek treatment at one of the missions in the (friendlier) north. This is not entirely different from Makdisi's description of the work of evangelical missionaries in the Levant during the nineteenth century: "the natives were from the outset more interested in technology and influence that the Americans brought with them than in the evangelical message" (Makdisi 1997:694). Though many Iraqis may seem to fully embrace the "evangelical" message of peacemaking, some are clearly much more

(sometimes solely) interested in the technological/healing side of "reconciliation through healing."

In addition to acknowledging the nuance in perspectives held by Iraqis, a clearer picture begins to emerge when we complicate our understanding of the effects of unequal relations of power. One important contribution in Farmer's book, *Infections and Inequalities* (1999:9, 258) is the trenchant and sustained critique of "exaggerations of individual agency" that often lead to blaming the victim or altogether missing the effects of structural violence. Farmer's work is especially useful because it is presented more as an analysis of violence than a revisitation of structure-agency debates (that is, structural violence is not the same thing as the "structure" part of those debates). But the way that "structure" operates against "agency" is not always altogether different for Farmer than it is for others drawing on that debate explicitly (although see Farmer 2003:273 n.15), who sometimes conflate concepts like structure and exploitation (or even conflate "structure" with structural violence). Pappas (1990) has argued that a more useful concept is that of relations of power—and a concept of power that is sufficiently understood as being different from domination (a structural asymmetry of resources) or exploitation ("a specific case of domination, in which resources are used to bolster the interests of one group"). Pappas explains: "clearly the physician produces the valued curing, caring, and relief of pain. Simultaneously the physician reproduces trust, authority, control—that is, an entire structure of domination—through which exploitation becomes possible" (Pappas 1990:200).

What is important in this differentiation is the understanding that power can operate both negatively and positively to make certain things, like successfully finishing a tuberculosis treatment regimen (Farmer 1999:258), impossible, and others, like domination or exploitation of patients, possible. Unequal relations of power *make possible* exploitation, structural violence, or

symbolic violence, for instance, but they *do not imply them*. In fact, I would go further than Pappas to say that not only does healing (inherently an unequal power relationship, even more so in the case of an Iraqi patient and American physician) simply make possible and not guarantee exploitation, but that healing only *makes possible* (rather than automatically produces) "trust" or "authority." Further, I think if trust and authority are the effects of healing in question—that is, if the remaking of perceptions being critiqued is one of remaking animosity or distrust into trust or goodwill (and whether or not this changing of distrust into trust should be viewed skeptically as a continuation of war by other means) a better concept of creating trust or animosity or simply "changed perceptions" would be useful. I think this better concept may be found in Marcel Mauss's idea of *habitus* (later to also be popularized by Bourdieu and used productively in Bourgois and Schonberg 2007, Wacquant 2009, and, in a more Aristotelian fashion, Mahmood 2005 to name a few) in which, through power and discourse, bodies may learn, or be taught, to develop "aptitudes" (Mauss 1979). I begin from Mauss rather than Bourdieu because "remaking perceptions" is clearly an intentional, pedagogical endeavor, and, as Mahmood explains, one of the limits of Bourdieu's approach is "its lack of attention to the pedagogical process by which a habitus is learned" (Mahmood 2005:139). Thus remaking perceptions from distrust to trust, or from "unreconciled" to "reconciled" may be viewed as an attempt to teach individual bodies (and, again ideally, for those bodies to then go out and teach others), not simply as repression of them or "their agency."

When we understand the effects of power in this way, as acting in a productive fashion on habitus, as well as the nuanced perspectives Iraqis bring with them to the healing encounter and the (still differing and nuanced, though sometimes changed) ones they leave with—we see that this medical development and peacemaking project is neither a totalizing structure that

forces Iraqis from a disposition of anger at their violent oppressor to one of trust for its benevolent authority, nor is it simply an innocent humanitarian program that renders unimportant questions of power in light of the ability of the Iraqi/Kurdish/Sunni/Shia/Muslim/Arab patient to exert some form overriding agency. Instead, the effects of this relationship are to alter patients' and their families' aptitudes and dispositions toward the ability to trust or be reconciled with those that are performing the healing, but these effects will not simply cancel out or supersede other effects on an individual's habitus (for example, memories or stories of the U.S. siege of Fallujah)—instead, they may conflict or compare with, or add to them in some way (and thus possibly explain perspectives that are grateful for the American healers or the population of the U.S. but no less distrustful towards the U.S. government).

Conclusions: From Critique to Critically Applied

> "After a day or two I would suddenly step back, aghast that I was so involved with the military justifications for not using nuclear weapons—as though the moral ones were not enough."
>
> Cohn 1987:713

Carol Cohn concludes her important 1987 study of the "rational world of defense intellectuals" by discussing the importance of deconstructing "technostrategic discourse" and dominant "militarized masculinity and decontextualized rationality" so that other types of discourse may be created and alternative conceptions of rationality may enter the debate on nuclear and other warfare (Cohn 1987:717-718). Moving from and building upon an attempt to understand the use of broad perceptions of congenital heart disease in relation to macrosocial forces (the sickness CHD) in the first half of my argument, I have, in the second half, similarly attempted to deconstruct the discourse and models of aid and development used in Iraq in order

to identify the power relations that simultaneously make them possible and are perpetuated by them, so that alternative models may enter the debate on how best to interact with children and families with congenital heart disease.

Following Wittgenstein-via-Tully, I have argued that the sickness CHD can be understood in its use as a concept by those employing it, and that this understanding can be approached through the areas of etiology and treatment. The functions of causally linking congenital heart disease to violence for the families I spoke with are twofold: (1) to displace, memorialize, remember in new ways, or make sense of past violence, and simultaneously to (2) undermine the imaginary-exploding effects of an uninterpreted realization of the precariousness of human identity (Asad) or the analogous world-unmaking effects of an arbitrary, random and absurd suffering (Scheper-Hughes and Lock).

After understanding this link between perceptions of the cause of CHD and violence, we can see the importance of the juxtaposition of the treatment of CHD and histories of violence. For many Iraqi families, as well as those that are helping to provide treatment for their children, the use of this juxtaposition is a process of peacemaking or reconciliation-through-healing. Such a program is susceptible to many of the common criticisms of development or aid, some of which I have presented. However, I have attempted to "move forward" these criticisms by returning to both the ethnographic data to reveal the nuance and difference in Iraqi's perceptions of the "healer-other," as well as to critical and anthropological theory itself to complicate ideas of the effects of power on the families I worked with.

In an altogether different context, Talal Asad has argued that the best way to understand "Islam" as an analytic category is neither as a distinctive historical totality bound up with power, nor as a heterogeneous collection of items that need only be labeled "Islamic" by individual

informants; instead, he argues that it is more useful to understand Islam as a discursive tradition (Asad 1986b:14-17). I have attempted to adapt (and adopt) a kind of Asadian thinking to the very different project of understanding congenital heart disease and its treatment in Iraq. Instead of a totalizing structure of exploitation on the one hand, or a heterogeneous collection of unaffected perspectives from fully effective agents on the other, I think it best to view this medical healing project as a discursive encounter wherein relations of power may produce and affect the habitus (including dispositions, desires, perceptions, etc.) of patients and members of their families.[13] This "teaching" does not simply supersede or occur in isolation from, but rather always conflicts, compares, and/or combines with other effects on those individuals' dispositions, desires, and perceptions of/toward those performing the healing.

Lastly, I want to return to the quote that opened this section in an attempt to move from critique to "critical application." Cohn describes being aghast at her use of defense intellectuals' discourse and military reasons to argue against using nuclear weapons, "as though the moral ones were not enough." What I have tried to show here is that while Cohn's goal of deconstructing the prevailing discourse in order to be able to construct alternative ones with alternative rationalities is of outstanding importance and absolutely should be pursued by medical anthropologists and others, we also need to realize that if we can be allowed to take as our goal not just identification of power relations or creation of alternative discourses, but also an immediate reduction of suffering in the form of treatable disease such as a hole in a child's heart—that is, if medical anthropology is to have its "feet on the ground" and not just "speak truth to power"—then perhaps the moral arguments are indeed not enough. Perhaps identifying the instances and ways that individuals in neocolonies are not simply neocolonial subjects that are acted upon by totalizing structures of power, but are themselves learned and learning bodies

acting within discursive encounters (like the healing of congenital heart disease) will help us to determine *when* (not *that*) we may be unafraid of "speaking power to power." By this I mean, in this particular case, using arguments like "reconciliation through healing" (for their effectiveness) even while simultaneously attempting to deconstruct the discourses and identify the power relations that are inherent in, necessary to, and possibly perpetuated by such arguments.

Notes

1. All informant names are pseudonyms. Ages correspond to those given in 2010 or 2011.

2. Indeed, the colonial encounter and the creation of the nation state Iraq has implications for many other instances of violence that have taken place there—including sectarian conflict. Ussama Makdisi (2000) has argued this point in the case of Lebanon—explaining, for example, that there is no "pure" historical expression of religious violence or sectarianism in Lebanon. It was during the colonial and post-colonial periods that "religious violence became a crucial component of national expression" (Makdisi 2000:174).

3. I do not want to imply that sickness and illness (and disease) are regularly delineated and separate entities existing in the world. For instance, "community perspectives on cause" will not always be altogether different from etiologies or explanatory models. I imagine that the most common explanatory model among members of a group will, in most cases, also constitute the bulk of the overarching (if there is one) community perspective. My point in investigating sickness specifically is to choose—based on methodological conditions and theoretical interests—a particular level of analysis that is broad and allows me to pose questions in relation to "macrosocial forces." This is what I have in mind when I call sickness an analytic construct.

4. See, for example, James Tully's (1989) use of the work of philosopher Ludwig Wittgenstein to problematize typical conflations of the understanding and use of a concept with its interpretation by the specialist or scholar (or medical anthropologist). It is this former idea of "understanding"—the understanding of a concept in its use by those employing it—that I refer to for sickness.

5. On Arabic documents, "community" was translated to retain a geographic sense rather than, for instance, a political or religious one. Similarly, in interviews with Arab families I would often use "Iraq," while I typically used "Iraqi Kurdistan" with Kurdish families (though I also used simply Kurdistan or Iraq on a few occasions with Kurds).

6. Consanguinity is an interesting case—in both phases of my fieldwork it was only those couples who were themselves consanguineous that mentioned it as a possible cause. No other parents mentioned intra-family marriage as cause, and a few even refuted it when asked. Given the fact that consanguinity is a suspected cause among many physicians and NGOs, and the ability of those with perceived authority in the medical encounter to (purposefully or unwittingly) influence patient explanatory models (see, for example, White 2005:324) I originally suspected that this was not an "emic" perspective but one produced through interaction with physicians and aid workers (a conclusion Bayda seems to have affirmed). I am concerned with this explanatory model in particular not because it is constructed and influenced through interaction with others (which is no different from any other explanatory model—all are mediated and discursive), but because it places blame on a practice (intra-family marriage) that is seen as strange, dangerous, or even disgusting by many modern Westerners. This creates the risk of falling prey to what Farmer calls "immodest claims of causality" (1997:351-354), especially

dangerous in data-limited instances like these where they could feasibly lend to a readjusting of blame back onto the victims.

7. When I say Iraqi parents' horror at the precariousness of human identity is at least as likely to include their own children as anyone else, I am not making a claim about any natural, universal, or intrinsic quality of horror or of familial bonds. Asad has already refuted the first case: "What I want to say is not that horror is natural (indeed, it is always mediated by sediments and traces that have been inscribed in the body)" (2007:81), and as I stated previously, a problematization of the indestructibility of maternal bonds in the face of extreme inequality and structural/everyday violence may be found in Scheper-Hughes 1993. Both of these concepts are contingent upon relationships and upon dispositions and "sediments and traces that have been inscribed in the body." This applies as much to Scarry's notion of pain/suffering as it does to horror (see Asad 2003:79-85).

8. Fighting between various Kurdish groups (many of which, such as the Kurdistan Workers' Party, are officially designated "terrorist organizations" by Turkey, Iraq, NATO, the EU, the United States, and others) and the Turkish military is ongoing (if sporadic) in the south of Turkey. Not infrequently, this fighting spills over the border into Iraqi Kurdistan (see, for example, Tyson and Wright 2007; Watson and Comert 2011).

9. This quote comes from the conclusion of this particular NGO's narrated "video manifesto," titled "Reconciliation through Healing." The video may be accessed online at http://vimeo.com/26953164.

10. See Rogin 2010, paragraph 3.

11. See Bunting 2011, paragraph 4.

12. Although the term "development critique" may be descriptive enough for most, a subset of literature has developed around the concept of "post-development theory." See Rahnema and Bawtree 1997 and Saunders 2003 for examples.

13. See also Asad's thoughts on subjectivity in an interview with David Scott: "one has to think about temporality and causality, and one has to steer clear of the notion of a totally passive, malleable subject, of a totally decentered subject, as well as of a totally self-directing subject" (Scott and Hirschkind 2006:288). A concern with temporality and causality is partly what I have in mind when discussing the effects of the siege of Fallujah as "combining" or "interacting with" the effects of the healing of a Fallujan's child.

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