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Inscribing and Incorporating Life

The "scriptural" is that which separates itself from the magical world of voices and tradition. . . . Thus one can read above the portals of modernity such inscriptions as "Here, to work is to write," or "Here only what is written is understood."

—MICHEL DE CERTEAU

"We operate in a structure, a reimbursement structure, where if it's not written down, it didn't happen. . . . If it's not in writing, it didn't happen."

—"SALLY BRASCO," CHARITY ADMINISTRATOR

Throughout its social life, Center programs attempted to improve the corporal well-being of clients by reducing health disparities among Haitians (and others). Interventions included material support, access to care, educational opportunities, and public health outreach, all offered while also incorporating clients as residents of Greater Boston. These human service practices helped to improve "health literacy." Coined in 1974, the concept of "health literacy" was acknowledged internationally as critical to health promotion in 1997 (Fernández-Gutiérrez et al. 2018: 55). In its Health Promotion Glossary, the World Health Organization (1998: 10) defines health literacy as "the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand, and use information in ways which promote and maintain good health." The WHO distinguishes health literacy from the mere ability to read; individuals must possess nuanced skills enabling them to apply health information to their own and their community's lives (WHO 1998: 10). Establishing charitable social service programs to improve health literacy among refugee and immigrant populations recalls decades of work Catholic institutions have performed in North America to incorporate Others through bodily care, public health, and civic interventions (see Chapter 2).

Although the Center's adult education and health programs provided clients robust "wraparound" services to improve their health, livelihoods, and health

literacy, this chapter analyzes another dimension of corporate Catholicism enacted through charity—namely, how funder requirements to record human service encounters frequently produced individual and institutional dilemmas. From 2006 to 2007, the Charity managed more than 140 projects across multiple institutional sites.[1] A critical condition of social assistance was recording each project's activities, especially the successes and failures of care. A March 2011 interview with "Sally Brasco," a Charity executive with decades of Center involvement, illustrated the challenges of implementing what she named "the human service and social justice orientation of Catholic Charities." We discussed the agency history and structure and the impact of crises like the 2010 Haitian earthquake on charitable giving within the archdiocese. I later asked about former Charity staff claims that the ethnic and minority programs were burdened with more administrative duties than others. In response, Brasco said, "There are things that we have to do as a social service agency when we're dealing with contracts that require . . . a lot of writing and documentation. And I don't think everybody comes to this work wanting to document. It's a hard thing to do."

Brasco acknowledged the political, economic, and ontological insecurities (existential precarities) impoverished immigrants and refugees suffer while adapting to another culture. Social service providers needed to capture these complexities using specific forms of writing. Brasco continued:

> If English isn't your first language and we're asking you to document in English, that's a challenge. So, it just makes the work a little bit harder. . . . I understand, culturally there's some really good reasons not to document things. I understand the . . . cultural mistrust of people and authority, the cultural mistrust of government . . . and so I think . . . there are times . . . it's challenging for people for whom . . . this is not their first world . . . to understand.

Staff members' ability to record caring transactions—and extract descriptions of clients' aspirations, everyday behaviors, mental health statuses, and efforts to sustain their lives—necessitated trust. Working with populations mistrustful of authorities, such as actors fomenting *ensekirite* in Haiti or those causing (and responding to) violence and crime in Greater Boston, also required tremendous time, patience, and sensitivity. Trust-building labor could be simultaneously pastoral, political, and risky, especially for undocumented clients. Nevertheless, in exchange for aid, the gift of services obliged clients to accept formal programmatic inscription, administrative visibility, and ongoing monitoring. Yet, in 1999, the Charity was accused of requiring its minority-run programs both to pay additional overhead on funding received and to complete additional documentation of services "not required of white-run agencies" (Latour 1999). To what degree are fiscal and textual taxes levied more heavily against independently run, ethnic-specific human services? What is the cost to compassionate care?

Although I can neither confirm nor deny any explicitly racialist rationale for disparate administrative practices across the Charity network, I will discuss in this chapter how the documentary obligations of social service work could constrain institutional freedom. With hearty laughter, Brasco described how human service organizations like the Charity must transcribe charitable practices into written texts to receive institutional payment: "We operate in a structure, a reimbursement structure, where if it's not written down, it didn't happen. So, you know you have that really stark reality. If it's not in writing, it didn't happen."

Both the Center and Charity operate in what I have described elsewhere as the "grant economy" (James 2010; 179–80), an economy pivoting between gift and commodity economies. Grantees receive public and private funding, as well as subcontracts, to render services on behalf of the state and other private entities. Social service providers in grant economies are increasingly subjected to an audit culture. Knowledge about clients' lives is elicited, transformed, accumulated, and shared with donors—a form of commodification increasingly common in grant funded programs. There are differences between faith-based and secular social service agencies that merit distinction. Although many FBO laborers are concerned for their clients' souls in the theological sense, grant-funded compassion economies also compel such "pastors of the soma" (Rose 2007: 29) to recount their client's physical, mental, legal, economic, and other statuses—components of the secular soul—to external monitoring entities (see Chapter 2). While the documentary procedures analyzed here resemble the benevolent bureaucraft practices and processes I observed previously in postconflict Haiti, the textual production in Greater Boston conforms more closely to a *scriptural economy* in a relatively secure, rather than fragile, nation-state.

THE SCRIPTURAL ECONOMY

To recall, the historical concept of economy in the West composes control of resources in a household or community, management of bodily regimens, and theologically, the divine order governing creation and drawing humanity toward salvation. Jesuit scholar Michel de Certeau describes the "scriptural economy" as an "apparatus of modern discipline" (1984: 131). In this economy, textual writing—inscription—is an act of production permitting scribes to order and control a space, such as a blank page, to make legible and provide meaning to (and sometimes for) the vernacular voices and bodies of Others (Certeau 1984: 134–40). Scriptural practices are markers of modernity and progress in Western societies. An expanding technocratic class with mastery over language and tied to economic production produces the scriptural economy (139). Certeau affirms: "For the past three centuries learning to write has been the very definition of entering into a capitalist and conquering society. Such is its fundamental initiatory *practice*" (1984: 135–36; emphasis in original).

In my usage, "scriptural economies" incorporate embodied subjects into a regime of life and mode of living through writing and other textual practices. A goal is securing the health of the individual, community, institutions, and states monitoring such practices, a form of secular salvation. In many respects, contemporary population health work initiates an organization's educators, caregivers, and clients into secular scriptural economies. But theological exhortations sometimes motivate scriptural laborers to resist the textual obligations of secular auditors.

As our interview continued, Sally Brasco acknowledged how institutional reporting obligations instilled particular disciplines in service providers, but not without challenges:

> Compared to . . . a caregiver who says, "How could I possibly capture everything that I've done. *And* you might be asking me to capture things that I don't want to talk about in writing," so, we . . . constantly train [regarding] what's necessary to be part of a good note, what's not necessary to include, because there's a skill and a craft to that. And I think it's a training issue. That said, there are some biases that you can't get past.

By "biases" I am not sure whether she meant cultural inhibitions against revealing personal information, or staff desires to aid but not document others, as required of historical scientific charity and contemporary case management best practices (see Chapters 2 and 9). Staff reluctance to reveal social and cultural intimacies elicited through obligatory confessional practices might inhibit the transcription of clients' biographies. Regardless of the meaning of "biases," penning clients' private lives rendered these individuals visible and legible to donors, and potentially to civic authorities.

Health literacy educators, counselors, and case managers ultimately deploy a kind of pastoral biopower in their charitable labor. Pastoral biopower combines the affective power of care with the regulatory cultures of biopolitics on the state's behalf to propose "disciplines of the body and the regulations of the population" around issues of "propagation, births and mortality, the level of health, life expectancy and longevity" (Foucault 1990: 139). Furthermore, the scriptural obligations imposed on health literacy work also govern individual and collective lives to produce legible (secular) souls—whether counselor, instructor, case manager, or client—who collectively labor to reduce health disparities posing risks to populations, institutions, and state security. The programs also benefitted from an internal reservoir of available participants attending Adult Ed and other programs. The Center's health literacy programs' success rested as much on the faith and souls of its staff members as on the scriptural practices they enacted with students and clients to provide evidence of compassionate care in their respective management systems.

In this chapter, two cases—the Center's adult education and maternal and child health programs—illustrate how the textual communications among federal, state, and municipal funders, Catholic Charities and the Center, and Center

programs and their respective clients compose a contemporary scriptural economy. This economy was simultaneously pastoral, textual, biopolitical, monetary, and normalizing. The obligations of scriptural economies affected how Charity intermediaries—the Center's program managers—circumscribed the exchanges between staff members and their students or clients. Both Center programs demanded specialized documentation at every level of interaction with the Center's clients. In each case, staff members grappled with desires to offer education, social support, and compassionate care in a manner conflicting with the reporting requirements of funders and the Charity. Each case also demonstrates how increasingly bureaucratic practices with real economic repercussions disciplined student/client/customers, educator/providers, and the social service institutions themselves. Each also highlights the affective, moral, and ethical stakes of serving marginal populations at the intersections of the Center, Charity, Church, City, and State. Nonetheless, improvisation and resistance to the bureaucratic routines of service provision occurred regularly.

THE SCRIPTURAL ECONOMY AND ADULT EDUCATION

Alongside the daycare, the Adult Education Program was the Center's oldest and received state and municipal funding from the Massachusetts Department of Elementary and Secondary Education (henceforth, the DOE) and the Mayor's Office of New Bostonians. Adult Ed, as it was called, served individuals of mixed legal statuses. The program offered preliteracy classes (in both Haitian Creole and English), three levels of English as a Second Language (ESL), math, computer literacy, Adult Diploma, citizenship classes, and educational counseling (see Figure 19). In 2006, the Charity website stated the Center's education programs were designed to "provide Haitian and other adults with essential skills that will lead to life-long learning . . . literacy, and economic self-sufficiency." This description reminded me of Certeau's statement, "learning to write has been the very definition of entering into a capitalist and conquering society."

When I began volunteering as an English tutor, the program was transitioning under a new manager whom I call Catherine Hansen. From her I learned the Charity had hired her directly and she was instituting "a culture change" with a revised curriculum, "new activities and teaching techniques," and a student-centered, rather than a teacher-centered program. This culture change complied with a scriptural economy obligating educators to record clients' personal data for DOE consumption. At the time, the DOE required grantees to use a database to which it had direct access to monitor class sizes, enrollments, attendance figures, students' personal information, and their future goals—the System for Managing Accountability and Results Through Technology (SMARTT).[2]

Hansen told me the Center's teachers did not always know what the students' goals were. This reputed lack of awareness of students' aspirations was not solely

FIGURE 19. Adult Education bulletin boards. Photo credit: Erica Caple James.

a question whether instructors adequately pastored or mentored clients, but whether they successfully elicited student data textually. Such digital inscriptions influenced how well the DOE evaluated its grantees using the "2006–2010 Performance Standards for Community Adult Learning Centers."[3] "We get credit for them," Hansen said of the accounting practices documenting achieved results. A precise calculus determined one program performance measure, "Setting and Meeting Student Goals": "Total number of goals set divided by the number of students enrolled in the program" and "Total number of goals met divided by the number of students enrolled in the program." These figures were compared to a benchmark in which "programs set, on average, at least two goals per student per year," and "meet, on average, at least one goal per student per year." Another assessment was to "document goals met according to the Countable Outcomes Definitions and Required Documentation Chart of the Student Goal Sheet." When all performance measures were tabulated for each student—attendance, average attended hours, pre- and post-test percentages, learner gains, student goals, and educational functioning level completion—the average for all students was determined and converted into the program's "performance points." The programs' performance points for the previous four years of a typical five-year grant were averaged and called "cut points." Each institutional contractor needed between eighteen and twenty-five cut points to become eligible for refunding.

What textual practices were required of clients and educators to meet these criteria? To continue with "Setting and Meeting Student Goals," the Adult Ed counselors—typically multilingual speakers of English, Haitian Creole, French, and Spanish—met privately with students to set and record their educational goals on a digital "Student Goal Sheet" containing several predetermined categories. The

first, "Countable Outcomes Requiring Valid and Reliable Data/Documentation," ranged from "enter employment" and "obtain GED" to "apply for U.S. Citizenship" and "receive certificate of citizenship at oath ceremony." The evidence could range from data matches—using the student's social security number or, in cases of students without social security numbers, a self-report—to copies of application receipt notices or certificates of citizenship.

The accounting practices generated among counselors, instructors, and clients were means of tracking adult lives over time. A set of goals categorized under "Countable Outcomes Requiring Student Self-Reporting and Teacher Verification" obliged instructors to monitor clients' everyday livelihoods and behaviors. Student goals were categorized as economic (i.e., "be removed from public assistance"), educational (i.e., "increase computer literacy"), health ("quit smoking", "learn about HIV/AIDS"), parenting ("join an organization at your child's school"), societal ("enter military"), employment ("create a resume"), financial literacy ("develop a personal and/or family budget"), and others "not for performance accountability measures." The counselor entered each goal, the dates set and met, then progress toward student's goals were assessed and updated each quarter—at least in theory. This goal-setting exercise attempted to translate the personal desires, experience, activities, and knowledge of Center clients into technical data to be surveyed, tabulated, and converted into percentages and points benefitting the overall program—a modern economy of merits and satisfactions (see Chapter 2). The students undoubtedly achieved many goals through regular class attendance, attaining greater proficiency in their natal language or in English, and successes in the American labor environment.

The Adult Ed instructors and program manager inevitably faced double binds working in this scriptural economy. One point of frustration between Hansen and the teachers concerned daily records of student attendance and class size. Certain "rate-based" courses were to have a "fixed schedule, meet minimum requirements for intensity and duration, [and] have a fixed number of student seats or slots . . . the eligible cost of which [was] determined by an established rate per student instructional hour." Calculations for optimal numbers of students per class correlated with rates the DOE paid per student slot. Several Center teachers did not always record attendance figures accurately or in a timely manner. But to ensure agency payment, totals had to be entered into the SMARTT database. For some teachers, failure to enter this information was resistance; for others, the bureaucratic annoyance was not fully understood.

Instructors shared their exasperation with program manager Hansen's enforcement of DOE expectations. Several Haitian teachers felt some Haitian clients—especially the elders—attended classes for social support rather than to achieve literacy in Haitian Creole or proficiency in spoken and written English. One conflict between instructors and Hansen regarded two nonliterate Haitian elders who periodically attended the "Pre-Literacy ESOL" class without formal enrollment.

If discovered during a spontaneous DOE site visit, the two additional students could jeopardize the program's overall performance rating. To the chagrin of teachers, the two elders were ultimately barred from the class.

The scriptural practices the DOE compelled were intended to craft instructors who complied with circumscribed student-centered practices and clients who could become disciplined workers in a capitalist environment. The reported threat of impromptu DOE performance audits, both onsite and by database surveillance, provoked supervisory staff fears the program could be found noncompliant. This secular audit culture compelled difficult choices—whether to discourage teachers' spontaneity and flexibility to conform to donor rules or to bend the rules to extend compassion to clients. Those programs possessing disciplined scribes produced sufficient countable outcomes and could be rewarded with renewed funding.

Some staff members feared this form of outcome-based adult education could become another source of risk, particularly for undocumented students. Through the SMARTT database computer program, the DOE was able to access much of the performance standards data, including information on the student goal sheet. In order to receive services, students signed a release acknowledging the DOE monitored its institutional grantees to determine their success in helping students achieve their educational goals and future employment. Students were informed their records might be matched against the Massachusetts Department of Revenue's wage records, and their name, social security number, address, educational goals, GED test scores, and employment history could be checked. Although personal information remained confidential, one staff member feared the state would inevitably use this information to monitor students directly and to ascertain which clients might have undocumented legal status. If undocumented students' legal status became legible and visible to third parties with program data access, the educational classes would no longer provide sanctuary from the legal insecurities of everyday life. For some students, attendance in Center classes might pose a risk of being apprehended and eventually deported by public authorities.[4]

SCRIPTURAL ECONOMIES AND SANTE MANMAN

In contrast to the Adult Education instructional and goal setting work in the classroom, Sante Manman's program included extensive monitoring of pregnant clients through educational programming both on- and off-site. Case managers regularly completed detailed reports on services while incorporating clients into a geographical network of care in Greater Boston. Services ranged from instruction and health examinations to travels to various medical appointments and support groups. This form of mobile "accompaniment" (Farmer 2013; Watkins 2015) reduced barriers clients confronted in accessing care, whether linguistic, cultural, educational, or legal. Undocumented pregnant clients were eligible. In a September 2006 meeting

with Sante Manman staff members, the Center executive director reported that roughly 50 percent of the program's eighty-five clients had legal status.

Sante Manman staff members humanized the city while also working to incorporate their clients into a biomedical system from which they might have been excluded without such assistance. The program's mission paralleled the Charity's contemporary concern for healthy families and historical work to retain Catholic immigrant infants, children, and families within the corporate body of the Church. Although the program did not overtly fulfill an explicit religious charism, its maternal and child health focus interpolated charitable biopolitics within an emergent scriptural economy that primarily documented the lives of secular souls.

Much like Adult Ed, Sante Manman's life work was situated at the nexus of another set of networked public agencies, institutions whose interventions were mediated through clients' bodies. The constellation of maternal and child health interveners engaged in forms of what has been called "reproductive governance": "the mechanisms through which different historical configurations of actors—such as state institutions, churches, donor agencies, and non-governmental organisations (NGOs)—use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor and control reproductive behaviours and practices" (Morgan and Roberts 2012: 243). Sante Manman's maternal and child health interventions posed similar ethical dilemmas for staff members to those in Adult Education.

TRACKING BLACK LIVES IN INFANT "DEATH ZONES"

> "It's like a way of life to let black babies die," charged Allen Ball, director of the Harvard Street Neighborhood Health Center on Blue Hill Avenue in Dorchester. "This is the medical mecca. They shouldn't let the infant mortality be as high as Third World countries." (Kong 1990)

"It's like a way of life to let black babies die." I am sitting with Director Ball's reported statement for a moment. Letting others die as a form of life, a way of being in the world, suggests some lives are not worthy and their loss is normal or natural, especially when invisible. The second part of the statement—that in the "medical mecca" infant mortality should not reach the level of "Third World countries," also disturbs me. Apparently, the preponderance of deaths in some nations is also normal or natural, if still invisible. The proximity of Black infant deaths to centers of Boston's medical expertise creates more moral outrage, as if the disparities are more uncivilized, barbaric, or unthinkable precisely because of their nearness. But I cannot parse here why infant deaths are so high in the so-called Third World and what relationship those deaths may have to the medical achievements in so-called developed worlds.

In 1990, as reported in the *Boston Globe* newspaper, Boston's 1988 infant mortality statistics demonstrated the racial gap was widening between the deaths of White and racial and ethnic Other infants:

> Among whites in 1988, there were 7.9 deaths per 1,000 live births; among blacks, the rate was 24.4 deaths per 1,000. By comparison, Costa Rica recorded an infant death rate of 13.4 per 1,000 last year. The Globe's review of death certificates for 1989 shows that 70 of the 108 infants who died in Boston were black, while only 18 were white. Twelve babies were Hispanic; 8 were listed as "other." In the first half of this year, 32 of the 61 babies who died in Boston were black; 14 were white. The deaths were concentrated in Roxbury, Mattapan and Dorchester. (Kong 1990)

In comparing Boston's infant mortality rates to those of so-called Third World countries, the news report implicitly mobilized alarm, and perhaps shame, to suggest these health disparities were comparable to those reputedly resulting from nation-state underdevelopment.

Disaggregating infant deaths by race and ethnicity obliquely directed fault or responsibility for infant deaths primarily at the behaviors of impoverished individuals and populations of African descent. The causes were not solely reduced to individual behaviors and adverse health, but also included socioeconomic factors. Nevertheless, the disparities in infant mortality rates in Roxbury, Mattapan, and Dorchester—coupled with crime, violence, and entrenched poverty—caused state officials to label these neighborhoods "death zones."

> "Death zones" is the term state public health officials use for the Boston neighborhoods with high infant mortality rates. A review of crime, health and economic statistics for one zone, a 10-square-block area in Mattapan where 17 babies died in the last three years, offers a window on the problem: More than 30 percent of the families live in poverty. (Kong 1990)

The public health officials' assessment spatialized deaths within an ungovernable racial geography of poverty lacking adequate pathways to care. The ontological insecurity in such zones undoubtably produced stressors that disproportionately affected the bodies of Black pregnant women and their babies.

However, conditions like poor housing, interpersonal violence, crime, and other infrastructural harms rendered infant mortality as just one indicator of what has been termed "syndemic suffering." The concept of syndemic suffering describes "a set of intertwined and mutually enhancing epidemics involving disease interactions at the biological level that develop and are sustained in a community/population *because of harmful social conditions and injurious social connections*" (Singer and Clair 2015: 429; emphasis in original).

In addition to disease comorbidities (co-occurrences), social scientists Merrill Singer and Scott Clair (2015: 429) argue harmful social situations are also direct determinants of health. Health statuses like "malnutrition, substance abuse, and

stress," when combined with "health-threatening social conditions (e.g., noxious living, working, or environmental conditions, or oppressive social relationships)," produce a "dangerous synergism" that "contribute[s] thereby to syndemical enhancement of disease" (Singer and Clair 2015: 429). Media reports of high infant mortality rates in Greater Boston from the late 1980s and early 1990s suggest a syndemical context for poor maternal and child health:

> In 1987 and 1988, 51 babies were born weighing less than 5 1/2 pounds, including 11 who weighed less than 3 1/2 pounds; 42 mothers got inadequate prenatal care and three got none; 25 girls age 17 and younger gave birth. At least 70 children were poisoned by lead between 1979 and 1985. Last year, there were two murders, six rapes, 74 robberies, 129 aggravated assaults, 151 simple assaults, 47 calls for family trouble and 179 auto thefts reported to police. (Kong 1990)

High infant death rates were just one symptom of a heightened level of physical and environmental risk for the majority Black residents of these areas. Although infant mortality does not necessarily occur solely because of disease, its high rates reflected a public health crisis for marginalized racial and ethnic populations living in an industrial nation possessing immense biomedical resources. Because these high rates occurred within mere miles of "29 neighborhood health centers and 26 hospitals—16 of them teaching centers," one frustrated area clinician suggested:

> "Why don't we just shoot these pregnant women?" asked Dr. Yvonne Gomez-Carrion, director of obstetrics at Roxbury Comprehensive Community Health Center. "We tell them, 'Say no to drugs,' but there is no treatment for them. We say, 'Get yourself together and get off welfare,' but there are no jobs for educated blacks, let alone untrained welfare mothers. Shooting them starts to sound like a reasonable option." (Kong 1990)

Dr. Gomez-Carrion emphasizes systemic inequalities here, the lack of healthcare to mitigate the so-called personal moral failure of drug addiction. By stating even Black persons of higher socioeconomic statuses faced obstacles to attaining livelihoods in an economy lacking jobs, however, the physician calls attention to the challenges of structural racism and economies of scarcity. Proposing murder as a solution, even in exasperation, demonstrates the deep weariness and impotence caregivers felt to remedy the socioeconomic disparities negatively affecting both vulnerable and higher status Black communities in Greater Boston.

Geographer Ruth Wilson Gilmore (2007: 247) defines racism as "the state-sanctioned and/or extralegal production and exploitation of group-differentiated vulnerability to premature death." High infant mortality rates among populations of African descent epitomize "group-differentiated vulnerability to premature death." Despite the racial and socioeconomic determinants of poor maternal and child health, some clinicians still identified the etiology of infant mortality primarily in pregnant women's biology and individual moral and behavioral

failures. Another clinician supervising three community health workers who advocated for pregnant women in the Mission Hill area of Roxbury (near Harvard Medical School) thought there might be a medical reason for the high mortality rates, such as "an unusual strain of chlamydia." She later said, however, "It's not about some unusual strain of chlamydia. It's about unmet basic human needs" (Kong 1990).

At issue here is the degree to which infant mortality is a problem of sexually transmitted infections and, by extension, individual moral fault, structural inequalities like the lack of education or employment, racial and gender discrimination, and the effects of entrenched poverty, or some combination of these. Infrastructural problems like inadequate housing, environmental toxicity, and lack of transportation complicate these factors. For racial and ethnic immigrants, like the predominantly Haitian clients in Sante Manman, cultural and linguistic barriers, domestic violence, and legal insecurity intensified these complex material, social, and economic conditions. Although regular reporting of client statuses was a component of their duties to improve health literacy, it was difficult for Center staff members to capture textually how their clients lived with syndemic suffering.

The state of emergency that infant mortality rates posed to Greater Boston and, as will be discussed below, to the nation as a whole, provides context for Sante Manman's work tracking Black lives while seeking to improve client's health literacy. The program served hundreds of women and their families from 1989 to 2014 through tangible and intangible exchanges of care, information, and a model of case management now called "accompaniment" (Farmer 2013; Watkins 2015). Over its history, the program became a component of a scriptural economy incorporating pregnant women and their infants into a public health apparatus, one aspiring to mitigate the emergency of high infant mortality rates (deaths occurring from birth to age one) in the United States. In a 2002 television interview for a Catholic EWTN segment, former executive director Pierre Imbert described Sante Manman as an essential community-based program serving the most vulnerable:

> The Haitian Multi-Service Center is the only site in the Haitian community for pregnant women in the fight to decrease infant mortality and help women deliver healthy babies, fight against low birth rate, and to help families deliver babies of a weight that can guarantee survival. The focus is on the whole family and on the mother at a critical stage of pregnancy. We also assist the mother after the baby is born with breast-feeding. The . . . program helps fight domestic abuse through education and educates older mothers [regarding] breast cancer.[5]

Sante Manman was designed to fight disparities in infant mortality rates between so-called racial and ethnic populations, on the one hand, and White populations, on the other. Infant deaths were especially high among the native-born Black populations; they were extremely high among immigrants who self-identified as Black. The use of martial language to commence the campaign

against Haitian infant mortality and maternal illness, and to promote health, positive relationships, and good parenting was highly significant.

In 1989, when Sante Manman began offering services in the 12 Bicknell Street building, social conditions were no better for the Blue Hill section of Dorchester: "Signs of economic abandonment are everywhere, except for a plethora of billboards advertising cigarettes and alcohol on Blue Hill Avenue. One billboard towers over Morton Street with a picture of a baby and these words: 'If only they came with instructions'" (Kong 1990). As many Center staff members previously attested, the Franklin Field area off Blue Hill Avenue was similarly plagued with crime and multiple forms of violence. Given the routine suffering and "violences of everyday life" (Kleinman 1997) in these neighborhoods, what interventions could address the structural challenges communities faced in so-called death zones? Given the syndemical roots of such social suffering, should government donors, hospitals, and public health agencies propose "community-targeted" interventions or should "community-derived and controlled" interventions informed by local sociocultural specificities be developed (Plough and Olafson 1994: 223)? What role did scriptural economies play in the maternal and child health practices in everyday life?

The high infant mortality rates publicized in 1990 sparked tremendous community outrage in areas where prenatal care was least available. In response, the Boston Department of Health and Hospitals (the predecessor to the Boston Public Health Commission) organized the "Walk for Healthy Babies." Alongside care providers and politicians, hundreds of mothers pushed babies in strollers from Roxbury's Grove Hall (two blocks west from the Yawkey Center) down Blue Hill Avenue to a rally at Franklin Field (two blocks from the original Center at 12 Bicknell Avenue in Dorchester) (Ribadeneira 1990). These health advocacy efforts produced several public health and community-based interventions—Sante Manman, for example—to reduce disparities in infant deaths in the city.

In 1991, one umbrella intervention emerged to target the infant mortality crisis in Greater Boston, the Boston Healthy Start Initiative (BHSI). At the time, BHSI was a consortium composed of the Boston Department of Public Health, community advocates, and local health institutions. BHSI was one of fifteen national Healthy Start projects aimed at implementing a standard community-based approach to reducing maternal and child health disparities. The Maternal and Child Health Bureau in the Department of Health and Human Services' Health Resources and Services Administration (HRSA) funded Healthy Start. In 1994, the Haitian Multi-Service Center's Sante Manman program became one of fourteen subcontractors for BHSI, Healthy Start's urban grantee in Massachusetts (Howell et al. 1997: xiii).

Despite this city-wide, community-based program to improve maternal and infant health outcomes, reported 1996–2000 statistics in BHSI project neighborhoods showed "obstacles to gaining access to care and disparities in underlying

health status and socio/economic well being continue to exert influence on perinatal outcomes . . . particularly for Black women." The analysis stated, "race and ethnicity continue to be predictors of poor perinatal outcomes in these neighborhoods." The same assessment identified additional problems related to lower health insurance coverage among "minorities and low-income individuals" plus troubling demographic statistics: "30% homeless or doubled up in housing, 25% who abuse alcohol during pregnancy, and 40% with repeat severe social risks." The majority of those whose infants died "experienced fragmentation and discontinuity in health care and that of their infants, including lack of follow-up and linkages across time . . . and across systems of care (medical and social)." In addition to domestic abuse preceding repeat unwanted pregnancy, the same report stated that 38 percent of cases displayed patient-provider challenges: "Interviews with women of color, in particular, emphasized how race, class and cultural differences between patients and providers often lead to miscommunications that leave women feeling disrespected."[6]

To reduce this broad array of factors maintaining disparities, BHSI sought to increase the number of women receiving prenatal care and case management from the first trimester through the postpartum period and to increase the percentage of infants tracked by case managers through age two. The program had extensive community training and organizing activities, including the "Father-Friendly Initiative." Another goal was to decrease the percentage of participants experiencing maternal depression, which could result from personal or family history, marital challenges, and unwanted pregnancy. [7]

Like other grant-funded projects previously analyzed, the BHSI model displayed a form of "results-oriented management" defining specific objectives and outcomes to be audited periodically (see James 2010, Chapter 4). For example, the BHSI Project Period Objective 3 sought to ensure "100% of BHSI participants during the inter-conception period will receive family planning counseling and services . . . in a culturally and linguistically sensitive manner to women and their partners at their postpartum visit." Case managers were to guarantee provision of family planning education and attendance at "scheduled family planning service visits" (Boston Healthy Start Initiative 2005: 37).

As a nonclinical subcontractor housed in a faith-based institution whose rules prohibited promoting or providing access to contraception or abortion (see Chapter 5), I was curious to understand Sante Manman's approach, especially since facilitating access to family planning was a mandated component of the Healthy Start/BHSI model of care. Once again, I draw on the memory palace method to consider the role of scriptural technologies in incorporating and tracking client lives. Given Sante Manman's dependence on cyclical grant funding to secure programmatic life, what modes of being, care, and self-auditing were employed in Sante Manman's maternal and child health literacy practices? When the precarities of pregnancy in so-called death zones surpassed BHSI scripts, how did staff

FIGURE 20. Sante Manman infant clients. Photo credit: Erica Caple James.

members cope? What kind of affect and improvisation did everyday emergencies produce and were such acts captured in writing? Could such documentary practices accurately capture the determinants of improved Black lives?

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It is August 2006. I have just begun working with the Sante Manman Se Sante Pitit Program on the Yawkey Center third floor. The bright suite of rooms offers safety, knowledge, advocacy, care, and material assistance to clients. In a large closet to the right of the main reception area, freshly laundered secondhand baby clothes are stored as gifts for prospective parents. Another small room to the left contains a chaise lounge for clients to wait and rest, as well as a table and chairs. This space doubles as a classroom. At the far end of the room are large glass windows. Sunshine illuminates the interior. Plants native to Haiti flourish in pots along the windowsills, almost to spite the coldness of the fluorescent lighting and Boston's winters. On the left wall adjoining the windows, photos of many Haitian infants and children born to clients since the late 1980s form a multihued halo around a central indigo poster (see Figure 20).

Under the poster's bold cursive title, *Philosophy of Birth*, a wreath of pastel flowers surrounds a creed:

> *Birth is normal, natural and healthy.*
>
> *The experience of birth profoundly affects women and their families.*
>
> *Women's inner wisdom guides them through birth.*
>
> *Women's confidence and ability to give birth is either enhanced or diminished by the care provider and place of birth.*

Women have the right to give birth free from routine medical interventions.

Birth can safely take place in homes, birth centers and hospitals.

Childbirth education empowers women to make informed choices in health care, to assume responsibility for their health and to trust their inner wisdom.[8]

These walls are iconic. Their images enshrine Black maternity, nativity, infants, and families as worthy. They testify to the program's success in aiding Haitian and other women of African descent to deliver their babies successfully.

Throughout the Sante Manman suite, additional emblems of life promote biomedical conceptions of pregnancy and birth. A poster of a White baby warns about sudden infant death syndrome (SIDS). In the classroom, an abstract poster of a cobalt blue mother nursing a baby carries the message, *Lét manman se richès bebe* (Mother's milk is baby's riches). Anatomical models of the cervix in various states of health display graphically "Why Pap Tests Can Save Your Life." Each educational item promotes reproductive health literacy and healthy family life. Each also attests to the unseen presence of external authorities to which the program was accountable.

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Imparting public health information to primarily immigrant clients was part of the processes of promoting health literacy and incorporating clients into the public health apparatus. One of Sante Manman's early successes was its outreach to and education of the Haitian community on women's health. A 1997 Sante Manman Se Sante Pitit (SMSSP) "Breast Cancer Prevention Program Report" describes the program's efforts to educate Haitian women on the anatomy and physiology of the breast and to increase their knowledge about breast cancer. Like other program components requiring documentation of activities and interactions with clients, Sante Manman's public health objectives were similarly outlined as goals to be achieved:

- Educate Haitian women on the anatomy and physiology of the breast
- Educate them on the importance of the breast and its functions
- Increase their knowledge about breast cancer
- Educate women on breast self-examination and clinical breast examination and encourage them to get into the habit
- Increase their knowledge on mammography and its benefits
- Inform them on methods of treatment of breast cancer

Such trainings epitomized how poor, ethnic, immigrant clients were encouraged to adopt new biomedical sensibilities and senses of embodiment as they sought fuller civic incorporation. As the report outlines, objectives were achieved through "a carefully planned radio campaign that [included] live radio shows with guest

speakers, public service announcements on [the Center's] weekly radio show, and a series of breast cancer prevention workshops [and] video shows conducted both at the Haitian Multi-Service Center and other community venues." Center program grant documents estimate its radio programs reached nearly forty-five thousand Haitians. Staff members also conducted workshops at the Episcopal Church of the Holy Spirit and St. Angela Parish in Mattapan.

The breast cancer report also outlines how Sante Manman staff presented the breast cancer training to women students of the Adult Education Program, an in-house community outreach effort occurring with each new health prevention initiative undertaken at the Center. The public response to these programs was animated. After one radio show hosted by Dr. Nissage Cadet, a breast surgery specialist, the Center received twenty-five calls from "listeners anxious to have specific questions answered. The community asked questions about signs and symptoms of breast cancer and sought to calm their fears of mammography. Callers, often women with legitimate fear, were invited to attend subsequent workshops." In response to the education campaign, clients with undiagnosed breast issues were referred to medical centers. Haitian senior citizens who were already scheduled to have a mammogram were encouraged to keep their appointment and not fear the diagnostic technology.

Although Haitian women responded well to the breast cancer prevention program, continued outreach and education in the Haitian community was needed to eradicate "false beliefs and taboos" that "constitute barriers to many women taking effective measures to detect early and prevent breast cancer" (SMSSP 1997). The breast cancer program report concludes with an example of a workshop attendee named "Alice." At fifty-five years old, she had never previously conducted a breast self-examination or had a mammogram. During the workshop she found a lump in her breast and became very upset. Alice feared to seek treatment, stating, "I don't have anyone in my family who has a lump in her breast or cancer." The Sante Manman staff members referred her to Boston Medical Center and the Mattapan Community Health Center for a follow-up. Through mammography the lump in her breast was confirmed and removed. The report notes her appreciation of the program and that "even her husband called to say thanks for the program that prevented his wife's condition to become worse."

Informational materials that could be retained away from the Center supplemented Sante Manman staff members' direct instruction of clients. Once given to clients, however, the booklets, pamphlets, and brochures were not simply public health promotional resources one might find at a supermarket, library, or other mundane public space. From tangible reminders in English and Haitian Creole of how to improve one's health and health literacy, they became gifts of knowledge. These corporeal items offered opportunities for staff members to share their expertise and their facility not only with the English language but also with biomedicine. In sum, the materials Sante Manman staff members gave clients became

secular icons of care, knowledge, and advocacy that resembled the emblems of faith its staff members displayed in their personal spaces.

FAITH AND FAMILY PLANNING

Sante Manman staff were observant Catholics dedicated to advocating for vulnerable pregnant women, especially Haitians, while following Catholic prohibitions against promoting contraception or abortion. In addition to family photos, their workspaces contained small, framed images of the Madonna and Child. Other cubicles displayed small pictures of Catholic saints or framed inspirational prayers. Some staff members wore small pendants of the Virgin Mary or a crucifix on thin gold chains.

Just below the large windows, two Haitian case managers, "Marguerite Roy," a veteran who began working when the program started in 1989, and "Roseline Dorvil," a social worker who joined the program in the early 2000s, had large adjoining work cubicles. The program director, "Pascale Verenette," a Haitian nurse practitioner with more than twenty years of healthcare experience, had a private office to the right of the suite entrance in which she examined clients. She began working with Sante Manman in 1994, when it joined BHSI. Anatomical drawings of the human body lined the walls of her workspace, and other medical images designated her area as a clinical space of care and healing. A bathroom scale used to weigh clients lay on the floor near her chair. A stethoscope and blood pressure cuff were other biomedical technologies used regularly to monitor client health.

I met Nurse Pascale in summer 2005 at an HMSC Advisory Board meeting. She did not wear nursing attire, but carried herself with an air of authority that made a uniform unnecessary. Her presentations were efficient, and she was serious about her work with clients and her obligation to report the Center's status to the board. Briefly, in 2005, she became interim Center director when Executive Director Imbert went on sabbatical and did not return.[9] I did not know she would become a good friend, one whose resignation in 2008, after fourteen years of service, was a source of sadness and grief for many stakeholders. Nurse Pascale was one of more than fifteen staff members who left the Haitian Center between 2006 and 2008. The departure of employees would parallel a similar exodus of core advisory board members during this same period (see Chapter 9).

At one of its weekly meetings, Sante Manman staff members shared how they viewed their program, its history, and challenges of operating between BHSI and the Charity. In early years, the program offered support including case manager home visits, parenting education classes, translation assistance, referrals to other medical facilities, transportation to clinician appointments, and other services. The program sought to improve children's health, prevent developmental delays, and reduce child abuse and neglect. Recognizing how the lack of mobility posed barriers to clients' ability to keep both prenatal and pediatric appointments (Giffin,

Curry, and Sullivan 1999: 43), in 1994 Nurse Pascale added transportation support explicitly in Sante Manman's proposal for inclusion in BHSI.

Offering maternal and child health services with primary financing from a publicly funded consortium posed challenges. In spring 2007, Sante Manman had to begin finalizing work for the close of the fiscal year at the end of June. There were eighty-five clients being seen by the two case managers and the goal was to enroll a few more by May 2007. Nurse Pascale explained, when their child reached age two clients neared the end of their enrollment. The staff needed to replace departing clients to maintain a stable cohort through spring 2009, the grant's scheduled end. As in Adult Ed, preserving a client base was a delicate process. The three staff women continued discussing the pros and cons of program registrations.

In previous cycles, there were problems if too many women were enrolled without sufficient funds to cover expenses at the end of a grant. At a minimum, the program needed to sustain a caseload of sixty women; the maximum was ninety. Staff strove to enroll pregnant women in the first trimester in order to see Nurse Pascale and have baseline vital statistics measured for comparison throughout the pregnancy, such as their weight and blood pressure.

I then asked about contraception and whether they could speak about it with clients given the program's location in the Charity network. In terms of family planning, rather than facilitate such services directly, the staff members referred clients either to their primary care providers or to other health centers offering counseling and access to available contraceptive methods. At no point did the Sante Manman staff members facilitate access to abortion, and as discussed below, these women sought a wide variety of external resources to enable a woman to carry out a pregnancy, improve her mental health, and aid her family.

Without articulating either personal or programmatic prohibitions against providing reproductive knowledge to clients, the staff discussed with some trepidation the risks of imparting contraceptive knowledge directly to clients. One case manager said in Massachusetts the morning-after pill was available to women aged nineteen and older. Prospective users needed to show identification to buy this contraceptive. If a woman was eighteen or younger, she required a prescription; while not exactly an over-the-counter drug, the medication was still accessible with parental support. In strong terms the staff stated concerns about the side effects of birth control pills and reported how an underage girl had died after taking it. Marguerite, the most senior case manager, speculated about the potential harms if individuals who were nineteen years old or older purchased the morning-after pill and distributed it to others. Who would be responsible if the side effects of these medications harmed the client or someone else? Pascale exclaimed, even as a nurse she would not deal with contraception.

I was struck by the sense of risk emerging in this discussion. The fear was not about being found noncompliant with BHSI's mandate. Neither was the risk of sharing contraceptive information and training about violating Catholic

proscriptions against its use. Rather, concerns about liability for harm befalling a woman because of side-effects or the unlawful distribution of medication was a sense of risk I'd not previously heard debated at length in contested reproductive discourses. I wondered if the potential for harm to befall someone in relation to staff members' work inculcated a more widespread sensibility of fear among Center staff.

Despite outsourcing the family planning component of the subcontract, Sante Manman staff reported achieving stronger outcomes than the other thirteen hospital and community health centers in the BHSI network. Once when attending a meeting at the Massachusetts Department of Public Health, Nurse Pascale said someone criticized Sante Manman's nonclinical approach because it didn't provide birth control education. Such education and care should be a responsibility of health centers, she argued, especially because the Center could not offer injectable contraceptives like Depo-Provera or other modes of birth control, nor could they provide tubal ligations or IUDs. But in terms of birth outcomes, Sante Manman was most successful because clients' infants were typically 6 lbs. or more at birth, theirs was the best community outreach, and caseloads met benchmarks more than the clinical health centers with case management. Furthermore, at their audits, Sante Manman was able to have all client children immunized when the health centers did not. Hospital and health center clients might not attend postpartum check-ups even when located in the same facility as their prenatal care. In having a line item for transportation, the Center was more easily able to help clients keep appointments and, as a result, their tracking of client benchmarks was better than clinical facilities.

In comparison with historical reproductive governance strategies that abandoned, repressed, and even sterilized Black women in the United States (see Bridges 2011; Briggs 2017; and Roberts 1997), the Sante Manman program was pro-life or pronatal, improved birth outcomes, and promoted the health literacy, social welfare, and livelihoods of Black women clients and their families. What other factors made Sante Manman's efforts effective, even at points when the program faced termination?

Although staff members and program managers deemed the program efficacious, there was no guarantee Sante Manman could operate in perpetuity, regardless of its positive outcomes. In 2002, as the clergy sexual abuse scandal exploded, backlash against the Church and affiliated Catholic agencies reduced private donations to the Charity. The state, from which the Charity received more than half its revenue, was also in crisis. The remainder of the Charity budget was composed of "private contributions, United Way grants, and client copayments," but with "less than 2 percent of the agency's money" coming from the archdiocese. According to the *Boston Globe*, in 2001, the Charity "ran a deficit for the first time since the early 1990s, spending $720,000 more than it took in" (Abel 2002). By 2002, spending exceeded revenues by more than one million dollars. The Charity announced in

March 2002 its intent to "cut their $40 million budget by 15% and lay off up to 200 of their 1,400 employees" (Abel 2002).

Although Sante Manman's scope of work closely aligned with the Charity's historical mission to serve families, in 2002 it was reported as one of several programs for immigrants, racial and ethnic minorities, and mothers and children, slated for termination in the Catholic charitable network.[10] Although the *Boston Globe* article does not state what other fiscal management issues might have affected the Charity's budget, it continued, "Despite its distance from the church, agency officials say the current scandal has led many contributors to withhold checks. The agency canceled its annual garden Party at the cardinal's residence in Brighton; last year, that event raised $1.4 million" (Abel 2002), the majority of which would fund the Charity.

The Yawkey Foundation contributed five hundred thousand dollars in emergency funding to the Charity, which in turn gave Sante Manman one hundred thousand dollars to maintain the program until July 2002. In the scandal's wake, Sante Manman's contributions and the meritorious labor of the other programs at risk of termination—"El Centro del Cardenal, a youth education program for Latinos in the South End, the Edwina Martin House, a substance abuse treatment program for girls in Brockton, and Roxbury's Nazareth Residence for Mothers and Children [which provides] housing, medical care, and other services for poor families affected by AIDS" (Abel 2002)—yielded media attention for this major saving gift to the Charity. This gift came just a year before the Yawkey Foundation pledged five million dollars for the new building. At a time of corporate scandal it is likely Sante Manman's successes became emblematic of the Center's, and by extension the Charity's, care for the City's children.

PASTORAL BIOPOLITICS AND SCRIPTURAL ECONOMIES

Throughout the years of client care, BHSI affiliated providers were to offer "health education related to self-care and infant care; nutrition, breastfeeding information and . . . other health education [about] HIV, STI's [sexually transmitted infections], substance abuse, family planning, reproductive health, [and] parenting support" (Boston Healthy Start Initiative 2005: 7). Sante Manman's client base was primarily composed of "refugees or immigrants with low literacy skills, limited or no English speaking ability, no health insurance, and no or low paying jobs.". Clients often suffered from "family isolation and survival stress" (Sante Manman Se Sante Pitit 1997). The program maintained extensive health records for both mother and child. Although I did not have access to study such records, staff members once showed me tall stacks of lovingly handwritten notebooks containing client information from the program's earliest years. (I later helped to enter intake forms into the computer, without analyzing the data in any detail.)

As part of the intake process and during pre- and postnatal services, Sante Manman staff members administered to clients two psychological assessments, the Women's Health Questionnaire (WHQ) and the Beck Depression Inventory-II (BDI-II). The WHQ, a survey instrument designed by the BHSI consortium, contained "63 questions about the health and social well being of the participant woman." It was administered three times, "at intake, end of 1st year, and 2nd year after delivery" (Boston Healthy Start Initiative 2005: 68). The BDI-II was similarly administered three times during a client's participation (Boston Healthy Start Initiative 2005: 52). BHSI mandated case managers make nine home visits during a client's participation in the program, including in the first days after giving birth. Case managers monitored child immunizations and, for those in secular community health centers, client utilization of family planning (Boston Healthy Start Initiative 2005: 52). The program also solicited feedback through "client satisfaction surveys . . . at the end of pregnancy, 1st year, and 2nd year after delivery," that BHSI staff analyzed to discern programmatic results from year to year (Boston Healthy Start Initiative 2005: 68).

Similar to the Adult Ed program's SMARTT database and the access provided to the Massachusetts DOE, BHSI clients' health data were accessible to the BHSI main office, and by extension, to the federal Healthy Start funders in HRSA. Although each national Healthy Start site used different management information systems, they were required to submit a "minimum data set" (MDS) to HRSA incorporating 241 variables on twelve maternal categories: "characteristics of client, key dates of services and providers, pregnancy history, medical risk factors, behavioral risk factors, prenatal care, psychosocial services, scope and content of case management/facilitating services, individual development services, psychosocial and supportive services; other family members, delivery, [and] postpartum care" (Howell et al. 1997: 77). Each program was obliged to report 159 additional variables for infant clients: "demographic characteristics; characteristics at birth; health status at first pediatric visit and at age one; use of medical services; use of psychosocial support services, facilitating services, and individual development services; and mortality data" (Howell et al. 1997: 78).

According to HRSA's 1997 Healthy Start outcome report, none of the fourteen national sites succeeded in submitting complete data. Reasons for inconsistency included lack of access to collect data correctly, lack of incentives for clinicians to "comply with burdensome data collection requirements," particularly when program funding was only a small part of their revenues, and inconsistent entry of variables into local program site's own data management systems (Howell et al. 1997: 78).

Records of the clients' health status and all components of service delivery—calls, visits, and even missed appointments—were to be recorded and shared by formal report with the BHSI consortium. Each local program site received computers containing software providing BHSI direct access to client data. Clinical

data—such as client medical records, intake forms, prenatal progress records, labor and delivery records, and the six weeks postpartum record—were extracted from each of the fourteen program sites. Trained "medical record abstractors" collected infant health and pediatric visit records. Program staff members submitted monthly aggregate data reports to BHSI to "capture, besides the usual demographics, important non-clinical aspects of the BHSI component" such as depression rates and other "interconception aspects" (Boston Healthy Start Initiative 2005: 68). BHSI was also able to monitor uploaded program data through site visits and by using the MS ACCESS Database software (Boston Healthy Start Initiative 2005: 68). Nonetheless, Sante Manman staff members sometimes struggled with both the hardware and software the BHSI system required. "Something's wrong with the computer," was a regular refrain among case managers who needed to input their client's intake and mental health information. Indeed, computer crashes were frequent and contributed to the backlog of information requiring entry.

Besides the lengthy WHQ and BDI-II inventories, there were intangible aspects of the "direct relationships between case managers and families" not easily captured by these scriptural inventories (HSNRC 1997: 19).[11] The Sante Manman staff members facilitated far more than "care coordination," "women's access to and use of the perinatal health care and social services they need," "client empowerment," and improved "client and provider satisfaction" (HSNRC 1997: 19). Although its case managers hoped to recruit clients in the first trimester of pregnancy, doing so required trust and willingness for the client to be documented biomedically for nearly three years. In addition to educating clients and transporting them to and from their many health providers, other care practices included taking groceries to clients (those enrolled in Initial Response), lengthy discussions with partners and family members about maternal and child health, instruction about parenting and domestic relationships, and supportively counseling the pregnant woman.

Another component of care likely unique to the Center was gift giving. BHSI initially purchased cribs for clients, but discontinued the practice. Sante Manman staff members continually obtained donated items like baby clothing, equipment, and other paraphernalia and attempted to ensure clients' children and family members received gifts at Christmas. Other items were given at the Mother's Day celebrations (see Figure 21).

In many respects, such practices brought clients into a quasi-kinship relationship with Sante Manman staff members and the Center. In addition to the mentoring and accompaniment received, treating clients and their families as kin encouraged program participants to access services in a health network comprising St. Elizabeth's Hospital, Boston Medical Center, Mattapan Community Health Center, Bowdoin Street Community Health Center, and Carney Hospital. BHSI consortium members met monthly with willing clients to offer additional support (a program component to which I did not have access). The 2003 Sante Manman "Program Abstract" attributes program successes to the relationships between

FIGURE 21. Sante Manman Mother's Day gifts. Photo credit: Erica Caple James.

caring staff members and clients "built on longevity and trust." These clients in turn referred family members, friends, and other associates to enroll during their own pregnancies. Such associations were able to "empower clients to maintain healthy lifestyles after they have left the program" (Sante Manman Se Sante Pitit 2003: 2).

CENTER MARIANISM

A favorite time of day was when the Sante Manman staff joined with health promotion and elder psychosocial support program women staff members for a mid-day meal. Most brought food from home, and we sat in the small second floor room overlooking the rear yard. Each of the primarily Haitian women had their own culinary specialty. Nurse Pascale typically brought flavorful and filling rice and beans, and sometimes *legim*, meat slowly simmered with vegetables and spices to liquefy into a fragrant stew. I wondered how they found time to prepare meals, care for client families, complete their professional work, and support extended family in the United States, Haiti, and elsewhere. A stroke suffered years before had disabled one woman's husband; another's adult son suffered mental health challenges and lived at home. Another woman managed adult-onset diabetes and was a single parent breadwinner in household that included her dependent mother. How did they care for loved ones at home, navigate the complexities of Center work, and aid clients to live securely in the United States?

At one lunch in March 2007, I asked, "How do you all do it?" I knew there was no magic formula, but the workplace ambiance of peaceful detachment and conviviality dispelled the vexations of everyday life. I knew their journeys from Haiti and the process of starting anew in the United States had never been easy. Struggles with the English language remained to varying degrees, especially when staff had to transcribe interactions with clients into reports of program activities. (After all, "if it's not written down, it didn't happen.")

In answer, one woman spoke of rising before dawn to cook supper for her immediate family before leaving for work. Another lived with extended family in a triple decker compound that provided some benefits of a familial safety net. She also labored as a nursing home caregiver while attending night school for an advanced professional degree. Their personal and professional achievements became benchmarks to which clients could aspire, but these successes required tremendous effort.

Center staff women deepened the Haitian American roots sown in Greater Boston through paths furrowed by courage and perseverance. As much as the obligations of transnational kinship and family could permit, their concern was to empower clients and care for their communities (and themselves). Indeed, as case manager Marguerite told me, "Even when I go on home visits, I am helping my people and doing something spiritually for God." Each went far beyond the scriptural requirements of professional charity to help clients achieve their own goals.

I admired the Sante Manman team (and other Center staff members) and was honored to experience the place of kinship and maternal care they had created. As I recollect and now write, I know I could have asked them to analyze further the gender dynamics in their own lives. I could have questioned whether they considered their work a form of reproductive governance replicating the asymmetries of power between the sexes in the United States, Haiti, and globally. I also could have challenged more aggressively Church doctrines on life, gender, sexuality, contraception, and marriage, as well as the hypocrisy of the abhorrent clergy sexual abuse scandal. But interjecting such questions into these intimate exchanges might have prevented my learning other lessons—about ethics, care, mercy, and how to persevere, despite the many obstacles at work and in everyday life.

For most of the Center's women staff, active involvement in their respective churches, especially prayer services, sustained private piety. I marveled at their faithful certainty; matriculation in divinity school and extensive training in anthropology had done much to deconstruct my own. Several of the women encouraged me to learn to pray the rosary as another path to explore religious faith. In the rosary, a scripturally based meditation, repetition of the Hail Mary prayer frames contemplation of significant episodes in the lives of the Madonna and Child. Encouragement to explore this devotion suggested prayer and connection to the Virgin Mary underlay their own faith and life practices.

At a lunch in late March 2007, several women shared their experience attending a conference for Catholic women in Boston, especially how the keynote

speaker's story demonstrated the power of the rosary.[12] Marguerite spoke at length about Immaculée Ilibagiza, a survivor of the 1994 Rwandan genocide. Immaculée was hidden with seven other women in the tiny bathroom of a Hutu man who was sympathetic toward the persecuted Tutsis. While concealed, the women repeated the rosary as many as forty times a day. They were not detected during repeated Hutu death patrols of the area. Although every member of Ilibagiza's family was slaughtered, she shared with the convocation, "I didn't know how to move on, but I said to God, 'God, I have just met You in the bathroom. I know You can act.'"[13]

I've since pondered whether the story was so compelling to the staff because Ilibagiza, like many struggling Haitian women, left a nation scarred by cycles of political violence and persecution. Perhaps the story reaffirmed the efficacy of piety. Although the Center women's devotional practices occurred amid different difficult circumstances, the women were no less fervent or sincere. In the context of shared meals, these caretakers taught me much about what could sustain and promote life. In their own way, these women staff members deepened the quiet reservoir of pastoral power at the Center's heart to be shared with the clients and each other.

MOTHERCRAFT

With professional maternal expertise, the Sante Manman team conveyed care and appreciation for their colleagues' and clients' dignity through "mothercraft." Historically, mothercraft referenced an early twentieth-century mode of public health instruction of women and girls. Rooted in positive eugenics—the promotion of desired population propagation—mothercraft aimed at creating hygienic families and improving public sanitation. Negative eugenic ideals sought to curb the reproductivity of populations deemed morally or physically degenerate, feebleminded, or socially disordered (Klaus 1993: 14).

As population health was correlated with national health and productivity, the maternal and infant health movement became an international one. Women's bodies and social roles became the nodes at which so-called public and private spheres converged. In early twentieth-century France, radical republicans "focused their attention on women's wage labor as the most important cause of infant mortality and an important factor in the decline of the birthrate and the disordered state of working-class morality and family life" (Klaus 1993: 14). In early twentieth-century Britain, "Child-rearing was becoming a national duty not just a moral one . . . To be good mothers they now needed instruction, organized through the various agencies of voluntary societies and local government, in the skills of what came to be known as mothercraft, as they were being defined by the medical profession" (Davin 1978: 13).

Immigrant women's literacy, behavior, and bodily health similarly became targets of early twentieth-century American interventions to mitigate perceived declining patriotism and lowered national standing resulting from diminished public health. Programs intervened to preserve the primacy of elite Whites:

> "Race suicide," a concept widely accepted among Progressive reformers of all varieties, reflected a concern with the changing composition of the American population, as upper- and middle-class whites bore fewer and fewer children while more prolific immigrants from southern and eastern Europe filled the factories and slums. . . . Urban public health officials in the United States traced the causes of infant mortality partly to poverty and defective public hygiene, but they placed the primary blame on the ignorance of immigrant mothers." (Klaus 1993: 16).

In 1920, Nurse May Bliss Dickinson, chair of the Mothercraft Committee of the Massachusetts Federation of Women's Clubs in Boston, presented "the Mothercraft Movement" before the American Public Health Association as an emerging solution to this crisis:

> Mothercraft, now introduced into twenty-five states and several foreign countries, is a very recent development in public health education. It seeks to utilize the maternal instinct of young girls and build on it a knowledge of simple hygiene and sanitation. The child carries this instruction to the home and the standard of home health is raised.[14]

The mothercraft system's instruction of girls "leads them naturally into the subject of baby hygiene and the right care of the baby in the home" (1920: 201). The Massachusetts mothercraft movement envisioned supporting government agencies such as state and local departments of education, departments of hygiene, and Red Cross efforts to solve "urban and rural problems" (1920: 202).

Mothercraft practices expanded throughout Europe and its colonies to improve infant and maternal mortality, and to mitigate the impact of population losses on national and colonial productivity. British "maternal imperialists" (Allman 1994: 25, citing Ramusack 1992) implemented public health policies among colonized Asante women in Ghana designating infant mortality as a "failure of motherhood." Colonial efforts to control the reproductive labor of Asante women were inextricably linked to control over their productivity in the colonial economy (Allman 1994: 28). Similarly, early twentieth-century Belgian "doctors, Catholic missionaries, and state agents lamented the low birthrate as well as the high infant death rate in the colony" (Hunt 1999: 241). The declared demographic emergency conveyed modern anxieties about population loss, infertility, and low birthrates among Europeans in the metropole and among Congolese laborers and their families in the colony (Hunt 1999: 243). Although Belgian copper mining industrialists in the Congo executed "a pioneering maternal and infant health care program," Catholic nuns were among the missionaries who intervened to transpose "ideas emanating from social Catholic pronatalist movements in Belgium" to the colony on behalf of the state. Historian Nancy Rose Hunt asserts: "understanding this Belgian colonial exceptionalism requires noticing how integral maternal metaphors and procreative logic were to the convergence of interests among capital, church, and state on Congo's Copperbelt" (Hunt 1999: 244). In all these examples, conceptions of race

were inextricably linked to ideas of sex and gender, health and hygiene, education, and the productivity of the nation-state.

These early twentieth-century relationships among capital, church, and state, and maternity, migration, and (re)productivity, reemerged in late twentieth- and early twenty-first-century infant mortality interventions in North America. Although conducted in very different political and economic contexts, there are similarities between the medical missionary work in the colonial era and the hybrid governmental and nongovernmental tracking of life in the Healthy Start and BHSI programs. A particular similarity recalling Lynn Morgan and Elisabeth Roberts's definition of reproductive governance is the public deployment of secular and faith-based community organizations to educate women and transform their bodily practices and hygiene in their private homes. This kind of instruction recalls both the historical senses of mothercraft and what Katharine McCabe (2016) calls "neoliberal mothercraft."

In contemporary neoliberal governance regimes, the state outsources the fulfillment of social welfare, healthcare, education, safety, and other public entitlements and infrastructure needs to private corporations and agencies. Under such conditions, privatized markets or economies converge with new sociocultural norms, as well as expert knowledge and technologies, to transform citizens into self-governing, risk-bearing consumers: "Experts derive their power from teaching citizens normalizing scripts for how to contend with social insecurity and manage risks which are in part accentuated by neoliberal divestment in public resources" (McCabe 2016: 178). Neoliberal "intensive mothering" projects impose "gendered expectation that mothers manage risks and adopt moralized maternal identities through their consumption behaviors" (McCabe 2016: 178). Scriptural and documentary practices provide the evidence of services delivered, maternal mentalities educated, immunized children, and other outcomes of strategic objectives designed to affect public health on the state's behalf.

Contemporary comparisons of infant mortality rates in the United States to other developed countries above also recall historical concerns with national health, eugenics, race, and immigration. At this writing, the national Healthy Start program states:

> Though infant mortality has declined in the United States over time, the U.S. has been slower to improve our consistently higher average rate of infant deaths than other industrialized countries. According to one source, in 2019 the U.S. ranked 34th out of 44 countries, with countries such as China, India and Turkey the only ones with worse IMRs. Russia's IMR was better than the United States at 5.1 deaths per 1,000 live births.[15]

Embedded in such comparisons are concerns with national health and development, the reputed degenerate effects of marginal populations on public and national health, and questions of the obligations states or governments have

to care for, protect, and improve the lives of others. The statistics also point toward the modest success of programs like Healthy Start and drive a larger question: why are women's health, fertility, morality, and nativity the focus of demographic interventions rather than the structural, racial, political, and socioeconomic conditions that strongly give rise to population vulnerability?

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In their own words, the care staff members provide to clients is maternal, engendering biopolitical charity with ideals of motherhood, protection, discipline, and gentle correction—producing a feminine or maternal form of pastoral power. But the efficacy of such work also lies in case managers' patience, expertise with Greater Boston's health resources, and perseverance to remove barriers to client success. Roseline Dorvil, a Sante Manman social worker, emphasizes staff commitment to help clients solve social problems as integral to programmatic success:

> *ECJ:* Why is this program effective or why is it successful?
>
> *RD:* The program is very successful. Because, when a client comes to the program, we do a lot with the client. We start doing prenatal education and . . . we make the client comfortable to talk about herself, and by talking about herself the client shares things with us regarding her own house and . . . family. By this we can see what needs the client really has and we help, we try to help her on those, too.

Through the establishment of rapport and sustained contact, staff empower clients inside and outside their families and homes, even when living under precarious circumstances. Roseline continued:

> For instance, there are some clients [who] don't have a house. . . . If they have three children, a husband, and herself, they probably have, maybe, two rooms. And that client always tells you, "I'm looking for housing." And what we did in the program, we referred the client to the Boston Housing Authority. We give them the address. . . . If they can't go by themselves, we go with them. If we cannot go with them, we tell them to bring the application we help them to fill out the application.

Housing instability, a major determinant of health, is a condition of living with overcrowding, having difficulties affording rent and household expenses, or paying most of one's income on housing. Another feature of housing instability is living in contexts exposing residents to health and safety risks.[16] Roseline claims that eviction from a residence and homelessness pose extreme threats to clients' health and access to healthcare. That kind of everyday emergency in the context of syndemic suffering requires exceptional interventions from case managers. Roseline explained:

> Some clients . . . are pregnant, but they are living with somebody else, and the baby is going to be born [but the client has] no house [of her own]. We explain [to] the

> client how we have a shelter that has . . . [worked] with us [for] a long time . . . and that shelter only receives prenatals. If she wants to go, we call for them, set up an interview. If they have space, they [accept] the client for us. . . . The shelter helps the clients to apply for AFDC;[17] now the client can have an income by herself. And, [in] the same way the client can also apply for housing . . . because when you are in the shelter it's better for you to find a house [as soon as possible]. So, we did all of those things. You know, we worked with the client every day, anytime they want us, you know, any concern they want to share, any issue . . . And like a mother. We can say like a mother, right Marguerite?

Contemporary, pastoral power "works through the relation between the affects and ethics of the guider . . . and the affects and ethics of the guided." Such affective exchanges or economies are "translated into a range of microtechnologies for the management of communication and information" (Rose 2007:74). In their deployment of mothercraft, case managers addressed social, cultural, and linguistic barriers to care, while developing familial relations with clients—"like a mother." There developed an affective exchange between staff member and client conveyed through a variety of communicative actions engendering pastoral power.

As confirmation of the affective kinship produced between case managers and clients, Marguerite lamented in an interview how case managers were prohibited from touching clients for several years, even to provide supportive comfort.[18] Although she was unable to console clients using touch, she continued, she might, sometimes on a home visit—after administrative check-ins were completed and only if the client was in extreme distress—read Christian scripture passages to lift their spirits. This statement, made on a single occasion, was one of the only times I heard faith described as gift or remedy one could offer clients. The only semi-public indicators of piety were the discreet personal items at a few staff members' personal workspaces. Perhaps entering a client's homeplace relaxed any customary restrictions against sharing the faith in Catholic charities agencies.

Other intangible dimensions of the pastoral, caring relationship not easily recorded in a case note were present on the few occasions I accompanied staff on home visits. As mentioned previously, case managers were scheduled to make nine home visits to clients, and clients came to appointments at the Center in between home visits. One sunny morning in July 2007, Nurse Pascale invited me to accompany her to see a young Haitian mother who had just delivered a son. Because my research terms limited observation of individual meetings between Center staff and clients and any access to individual case files, I quickly agreed to go. I could not resist an opportunity to visit a client's home. We drove through sections of Boston with high concentrations of Haitian businesses and residents to reach the client, whom I call Guerline Isidor. On our arrival at a small reddish brick apartment building, a friend met us at the door and led us to the room where Guerline was resting. Rather than using formal assessments, Nurse Pascale checked Guerline's health and mental health through pleasant conversation

and admired her son, whom I call Mathieu. During this tender exchange, I was, I am embarrassed to admit, transfixed by two components of the domestic scene: throughout the discussion a cigarette brightened to a glowing ember with each of Guerline's deep inhalations. Secondly, although I did not know his weight, baby Mathieu was tiny, barely six pounds. I wondered if Guerline had smoked throughout the pregnancy or if her smoking was rare. If routine, could smoking have had any relationship to Mathieu's lower weight? After Pascale shared more warm words of encouragement, an embrace, and gratitude for Guerline's willingness to have me visit, we left for the Center.

I was curious how the visit would be documented and whether Pascale would record Guerline's smoking in the obligatory case notes. While en route I asked her about the young mother's cigarette use. She said many Haitians have one cigarette in the morning and that it was not such a big deal. She chided me (gently) and stressed a more critical issue. Guerline had been in an abusive relationship. She was starting over alone with support from the Center. I was justly admonished, but still wondered about Pascale's report. If she disclosed cigarette use, or commented on the reputed cultural difference in their consumption in Haiti, would this information alarm BHSI's central administrators? Conversely, would Pascale document the kind and motherly way she congratulated and reassured Guerline whenever she transcribed the encounter? After all, "if it's not written down, it didn't happen."

In an interview, senior case manager Marguerite expressed exasperation with the burdens of inscription: "The services offered to clients are less than the paperwork." In late July 2007, Marguerite brought me to visit two clients. Although she had confirmed the appointment with the first client just before we left the Center, when we arrived, the young woman had left the home. Perhaps her absence was a form of resistance to case management. In hindsight I worried the client regretted agreeing to have an unknown visitor enter her homeplace. Marguerite was nonplussed and said sometimes clients missed appointments. We left to visit "Beatrice Sanon," a pregnant Haitian woman in her late thirties who had two children living in Haiti. Marguerite had already completed the WHQ, the BDI-II, and other intake forms by phone. What remained was a face-to-face meeting for Beatrice to sign the documents, one of which allowed the Sante Manman staff to request personal information from her health care providers should they be unable to reach her. Marguerite told me clients were sometimes difficult to trace. They moved frequently and sometimes left the city or state in search of work or other means of living.

Beatrice resided with her boyfriend and was expected to deliver her baby in early August, just a few weeks before me. Her sparsely furnished, air-conditioned basement apartment in a modest building on the border of Mattapan and Hyde Park was comfortable. Once seated, Marguerite spoke with Beatrice mostly in English. From her slight accent I would not even have guessed the client was Haitian until the conversation shifted to Creole. Beatrice had been faring well but lamented not having family nearby close to her delivery. She was frustrated her

partner couldn't take leave from work to stay with his child. Moreover, her sister was having her first child in New York in August. As their mother lived closer to her sister, she was going to remain at home rather than travel to Boston for Beatrice's birth. Marguerite reminded her it was her sister's first child and that she also needed support. Marguerite's own daughter was also expecting her first child. Although compassionate toward Beatrice, she shared her enthusiasm about her first grandchild as another perspective on Beatrice's mother's decision.

The conversation was familial and pleasant, then unexpectedly shifted to differences between giving birth in Haiti versus the United States. Beatrice said she had decided never to give birth in the United States after witnessing how hard it was for American women, especially single mothers of limited means, to manage parenting. She mentioned seeing a woman with a newborn at a laundromat trying to do laundry alone. The woman appeared exhausted. Beatrice vowed never to have another child. "Yet," Marguerite said, "here you are."

I asked how things were different in Haiti. I remembered working at the Chanm Fanm clinic in Martissant the day a young woman in active labor came, asking to give birth inside. She was turned away. The physicians were not mandated to do deliveries and could not admit the young woman. Perhaps the staff also feared accepting the risk to provide care when the outcome was unauthorized and uncertain. She ended up having the child in the street.

Marguerite, the oldest child of ten, told us the story of her mother giving birth in a Haitian hospital. In the days following her release the doctor visited their home to check how her mother was feeling. Nurses came to give her sponge baths and her mother remained upstairs with the newborn to rest and recover. She recalled that the family prepared special meals to help fortify her mom—oatmeal in the morning, and bread and hot chocolate before she went to sleep. It was a time of pampering for a month following delivery. Marguerite and Beatrice were nostalgic for the care and loving attention shared postpartum in Haiti, likely under situations of relative security, as opposed to the individual and sometimes solitary experience of giving birth in the United States.

When back at the Center I asked Dr. Oscar, the Initial Response physician, about traditional birthing practices for mothers in Haiti. Within twenty-four to forty-eight hours after a birth, he said, mothers are given a hot steam bath, then massaged with *lwil maskriti* (Palma Christi oil or Haitian black castor oil). While our discussion of traditional Haitian birth practices continued, we unexpectedly learned more from a staff member with whom I had had only passing, but pleasant, interactions. By chance, Alcide Isaac, the Yawkey Center custodian, joined us and greatly enlivened the conversation. In Haiti, before her death, Alcide's mother was a *fanm chay* (*fanm saj*, midwife). He had served as her assistant and gathered firewood and herbs for an herbal bath for the delivering mother. Dr. Oscar added that women in Haiti often know in advance when they are going to deliver. They might go to the market earlier in the day or run errands, and then would call the *fanm saj* toward evening.

Alcide shared there are *tizàn* (teas, infusions) given to help *chofe* (heat up, accelerate) labor if it is not progressing properly and other remedies to lessen contraction pains. After the birth, the steam bath is given. Water is heated in a bucket, then a variety of herbs and leaves from mango, papaya, and sapodilla trees (among others) are added. When ready, the new mother stands over the bucket. As steam envelops her body, she is washed with the water. The bathing helps the *move san* (bad blood) to *desann* (descend) and *sòti kò-a* (leave the body), "*espesyèlman san ki gen tan* 'clot' *deja*" (especially blood that has already clotted). After the bath, the new mother is massaged, especially in her abdomen, to stimulate her womb and encourage the blood to leave the body (*san vide kò-a*). Without receiving the massage, he said, the woman could suffer from *matris tonbe* (collapsed/prolapsed womb/uterus). When walking she could stumble and her womb could fall or be misplaced, affecting her future fertility.[19] Normally there are three baths given, three nights in a row, in the evening before sleep. If the woman has someone with her, she may not leave the house for two to three months.

In subsequent days I asked the Sante Manman staff members about these traditional modes of labor and postnatal care. Caseworker Marguerite said some Boston hospitals had permitted Haitian women to receive the postnatal massage. Although prenatal care was much better in the United States, she affirmed postnatal care was better in Haiti. But whether postnatal care could consistently be as healing and restorative as described remained a question, particularly given Haiti's cycles of *ensekirite*.

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The stories in this chapter show how life, health, education, and everyday care practices become objects of textual production, of translation and transcription, to demonstrate an intervention's efficacy and to enable institutions to demonstrate accountability to grantors. Attempts to convert life achievements into attainable objectives tend to individualize and naturalize many everyday life challenges. Goal-setting exercises, confessional practices, and formalized inventories of subjective states are affective performances and productions between staff members and clients. Such practices provide means of encouraging reflection, evaluation, and opportunities to seek expert assistance. In Sante Manman in particular, such steps facilitate the incorporation of women clients into the American biomedical system of birth, pediatric care, and organizational surveillance on behalf of municipal, state, and federal agencies. In both Adult Ed and Sante Manman, health literacy practices incorporate clients into scriptural economies that may stop short of enabling full citizenship; nevertheless, they facilitate paths toward civic inclusion. Some aspects of everyday charitable lives that may exceed scriptural templates of programmatic successes and failures involve culture—expressed through different ethics, moral senses, and caring practices—and structural inequities like racism, the roots of which appear unchallenged.