© 2009 Aren Isadora Del Vecchio
To my daughter Alithia
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Haitian migration to East Flatbush, Brooklyn began in the 1960’s. However, racist and paternalistic attitudes toward Haiti and Haitians by the United States had been occurring since the 1800’s. This relationship led to anti-Vodou campaigns in the early 1900’s, racist attitudes and segregation during the US occupation of Haiti, and, in the 1980’s, the Centers for Disease Control labeled Haitians as vectors for AIDS. Haitians were not passive they reacted to this relationship through protest and, often, were empowered when their protests were heard.

This thesis focuses on the experiences of Haitian identity and related health concepts which are negatively associated with AIDS, Vodou, and Blackness. These negative associations have affected the ways in which people adhere to or avoid folk models for health and explanations of health. An example of how these associations manifest is through the use and avoidance of folk explanations for reproductive issues and infertility. Women who use folk health categories hope to avoid the stigma associated with bareness. This thesis examines three main behaviors surrounding the ways in which folk models interact with AIDS, Vodou, and Blackness. First, health care providers consider folk illnesses and the women who use these theories negatively. Second, the historical and social context of Haitians in the United States impacts Haitian folk health and biomedical health models, and, third, women with reproductive
health issues use folk models to explain bareness due to the stigma associated with infertility rather than using US biomedical models.

Haitians in Brooklyn did not discuss folk illnesses with healthcare workers. These same workers felt that women who believed in theories of folk health were uneducated. Historical and social constructions of folk and biomedical models for Haitian healthcare are highlighted by the ways in which people apply folk models of health to themselves and to individuals. One way this manifests is that some women use folk illnesses as an explanation for infertility to avoid the stigma associated with bareness.
CHAPTER 1
INTRODUCTION

Fèy, O!
Sove lavi mwen
nan mizè mwen ye, O!
Pitit mwen malad
Mwen kouri kay gangan
Leaves!
Save my life.
I’m in misery, O!
My child is sick
I run to the house of the *Vodou* priest
--Haitian folk song

Introduction

This song, *fèy yo* (the leaves), found in the title of this thesis, and here in the beginning of chapter one, is prominent because of the importance of this song to a proud history of folk medicine in Haiti. This traditional song has been remade in both Haiti and the United States because of its popularity which addresses the political nature of people’s healthcare choices. The song’s lyrics do not state that when your child is sick you go to the hospital it states that you go to a *Vodou* healer. This song recognizes, and through its popularity, (re)recognizes both historically and presently, the role of *Vodou* in everyday healing practices. This is relevant because the Haitian experience with health and healthcare is what this thesis is about.

Haiti and the United States have a long political, militaristic, and medical relationship that has impacted Haitian culture. This relationship has been, in many ways paternalistic, with the United States acting as father and deeming Haiti the child. This relationship has affected medical institutions by favoring biomedical methods and theories over folk medical methods and theories. Negative associations with AIDS, *Vodou*, and Blackness flood United States policy implementation in Haiti and in the United States. Through this process, these negative associations have impacted the ways in which Haitians experience health and healthcare in the
United States, including their interactions with folk illnesses. This is important because it shows how Haitian immigrants living in the United States have constructed Haitian folk illnesses in a new country.

**Research Statement**

This thesis is about the experiences of Haitian identity and related health concepts which are negatively associated with AIDS, *Vodou*, and Blackness. These negative associations have affected the ways in which people adhere to or avoid folk models for health and explanations of health. Haitian identity and related health concepts are negatively associated with AIDS, *Vodou*, and Blackness by both Haitian and United States formal medical institutions. Experiences of health and healthcare in Brooklyn reflect these negative associations. This study researches how folk theories of health, in particular, *move san* (bad blood), *lèt gatè* (spoiled milk), and *ti moun mare nan vant* (the tied baby), and folk models for the spread of AIDS are associated with stigma.

My study has three statements, the first one stemming from the Brooklyn health advocacy’s community’s concerns with culture and healthcare. The last two statements are from my own prior experiences, beginning in June of 2000, with Haitians in Haiti and Miami. The hypotheses used in this thesis are:

1. The historical and social context of United States and Haitian relationships impacts folk health and biomedical health models concerning Haitians.

2. Health care providers consider folk illnesses and the women who use these theories negatively.

3. Women with reproductive health issues use folk models to explain bareness due to the stigma associated with infertility.

In order to give context to why the research statement has relevance I provide a background on how anthropology approaches illness, transnationalism, and race, and will
provide demographic information about Haitians in Haiti and New York. Next, I discuss the methodology of the research and then present and analyze the survey data and the interviews. Then, I conclude with research findings and ideas for future research.

In this chapter I will address the field site area and how African Americans, and, eventually, Caribbean migrants, arrived in East Flatbush. Next, I address how medical anthropology formed and Ruth Benedict’s role in putting medical definitions under scrutiny. This leads into the different, but connected ways of theorizing about illness studies, including studies concerning folk illnesses. Anthropological inquiry into this topic has shown that biomedicine is but one of many types of medical systems in the world. For instance, Afro-Caribbean folk medicine is based within an oral tradition and contains several different types of healers and categorizes illness according to the hot/cold dichotomy.

Third, this chapter addresses transnationality. This includes people who are politically socially, culturally, and economically invested in more than one nation-state—one in which they migrated to and the other where they migrated from. Social aspects such as race and ethnicity are important to transmigrants because when they migrate to a new country they are faced with understanding the ways in which race and ethnicity are configured in their new home. Haitians in general, and Haitians in East Flatbush, are transmigrants because they maintain connections to family and friends in Haiti. Theorists use “center periphery” and political economic theories to understand Haitian transmigrants.

Finally, the ways in which Haitians are stigmatized is addressed. Stigma as discourse includes social rejection, blame, shame, and discrimination. This can be seen when Black bodies are targeted as diseased. Throughout United States history, and, more recently, Haitian bodies have been blamed for disease spread. An example of this is when the Centers for Disease
Control (CDC) labeled Haitians as vectors for AIDS. After the CDC’s announcements the media incorrectly connected the spread of AIDS among Haitians to Vodou.

**The Field Site Area**

East Flatbush, a neighborhood in Central Brooklyn, was populated by Italians and Jews in the late 1800’s. This area saw large scale development in the 1920’s, and by the 1960’s was largely populated by people from the Caribbean (New York City Department of Parks and Recreation 2006). This area of Brooklyn, similar to many areas of New York City, was, and is subject to, residential segregation which is a long standing process which separates racial groups from each other (Grady 2006 and Kaplan and Holloway 1998). This affects Haitian migrants because before Caribbean migration was happening in large numbers institutional racism such as steering (showing housing to African Americans in predominantly African American neighborhoods) and red lining (banks refusal to lend money to people buying in non-white neighborhoods) focused on African Americans was happening in New York City. African Americans were steered toward Harlem, the South Bronx, and Bedford-Stuyvesant and because of these practices African Americans of all class backgrounds were forced to live in the same neighborhoods. When Caribbean migration began in the 1960’s these Black immigrants affected residential segregation in an expansion of Black neighborhoods in Central Brooklyn that now included Flatbush (Grady 2006).

Central Brooklyn contains some of the poorest neighborhoods in New York City with one of every three people living in poverty. Health indicators such as cancer rates, death rates, and infant mortality rates are higher in Central Brooklyn neighborhoods when compared to other Brooklyn neighborhoods while life span is reportedly lower in the poorest neighborhoods with Black New Yorkers specifically when compared with White New Yorkers (Department of
Mental Health and Hygiene 2004). These disparities make the study of Haitian migrant’s health to New York City matter to anthropology.

The Making of a Medical Anthropology

Early anthropologists’ questioning about the normal and abnormal in regards to illness categories framed the making of medical anthropology. Anthropology has a history of being linked to, and being purveyors of, colonialism or colonial mentalities (Good 1994). A good example of this in medical anthropology is the early focus on beliefs and practices which has continued into present anthropological works (Good 1994). In the 1940s, observations made by physicians and historians concerning non-Western health systems considered these systems of health to be primitive and to be a proto form of biomedicine (Ackernecht 1946). The study of medicine and medical anthropology is based in the empiricist tradition where reliance upon observation and experiment are important aspects of the research. However, within this tradition, even as early as the 1930s, it was noted (Good 1994) that the use of biomedical disease categories, when applied to non-Western peoples, was problematic. This is because this type of application does not, and did not; address the social aspects of the construction of illness knowledge. Thus, out of the Boasian tradition, an anthropology of physiology was born (Opler 1960 and Good 1994).

Ruth Benedict (1934) put medical definitions under scrutiny. She wrote that it is important to note that biomedical definitions of medical categories such as ‘normal’ and ‘abnormal’ are culturally specific and differ cross-culturally. In essence these are not homogenous definitions that define all societies in the same ways. What is normal for one society may be considered abnormal in another. Benedict pointed out that these definitions were relative to their cultural context. Critics of her theories of relativity as applied to mental health suggest the extreme relativity discounts the possibility of any mental illness. Benedicts’ mapping of ‘normal’ and
‘abnormal’, her writings on the importance of social response when dealing with pathology, and her ideas that abnormality and pathology are culturally interpreted, are a part of medical anthropological inquiry (Opler 1960; Modell 1989; and Good 1994).

**Four Approaches to Illness Studies**

Four approaches to illness studies are addressed in this section empiricism, cognitive anthropology, interpretive anthropology, and critical medical anthropology. While there are several different models and approaches that could be applied to illness studies, these approaches differ in some aspects, and they suggest a continuum of thought.

The empiricist paradigm shares much of its view with biomedicine. Its writings focus on belief and behavior models, where biomedical knowledge is the norm. In medical anthropology, a critique of empiricism occurs, but empiricism persists in anthropological theorizing and practice on health and medical systems (Smith Doody 1992). The persistence of empiricism is seen when medical anthropology is viewed as the study of medical beliefs and practices. According to Good (1994) empiricism for medical anthropology covers three things: “the analysis of illness representations as health beliefs, a view of culture as adaptation, and an analytic primacy of the rational, value-maximizing individual” (Good 1994: 39). The problem with the idea of ‘belief’ is that it is juxtaposed against ‘scientific knowledge’ as if the latter is somehow more correct. Belief is considered a misunderstanding whereas knowledge of something is considered understanding. The presentation of belief in this context occurs throughout anthropological literature and be seen in Lepowsky (1990). This idea of belief verses knowledge is closely linked to the empiricist notion of medical systems as adaptive strategies. This idea suggests that people adapt to their environment and that medical systems are a result of such adaptation.
Cognitive anthropology is another way to view illness representations. It shows that each culture orders all life events, ideas, and materiality within its own specific domain. Those who focus on medical anthropology focus on taxonomy of disease, folk theories of health and healing, and the ways in which illness narratives are structured (Conklin 1969; Colby 1996). Other early studies by cognitive medical anthropologists focused explicitly on disease classification (Frake 1961; Fabrega 1970; Fabrega and Silver 1973). These studies of disease classification helped to document the everyday use of medicine in a cross-cultural context focusing on taxonomy. In response to cognitive anthropology, anthropologists created a more interpretative approach.

Interpretive medical anthropologists focus on the relationship between culture and illness where disease itself is an explanatory model (Good 1994). This meaning-centered approach addresses three categories of illness study. First, it addresses the relations between biology and culture, and the phenomenology and trajectory of illness (Csordas 1983; 1988; Finkler 1983; Roseman 1988). Second, it addresses the symbolic structures and processes that occur with illness and illness therapy (Lock 1980; Nichter 1989). Third, interpretive medical anthropologists address embodiment or the idea that a person’s lived experiences contribute to illness which can present as illness in the body (Csordas 1990; Gordon 1990; Pandolfi 1990). The criticisms waged against this approach are that it is too theoretical and not practical for applied anthropologists, and it is too closely aligned with the biomedical paradigm (Good 1994).

Critical medical anthropology addresses how global, local, political, and economic issues affect health and medical systems (Richters 1988). Anthropologists draw upon theories of political economy, Marxism, and Gramsci’s hegemony as a way to understand health and medical systems. Hegemony is used in the Marxist context to show how the industry of medicine can be dominant culturally, socially, and economically. As Good (1994) writes, “A
critical medical anthropology forcefully poses the question of when illness representations are actually misrepresentations which serve the interests of those in power, be they colonial powers, elites within a society, dominant economic arrangements, the medical profession, or empowered men” (Good 194:57). These anthropologists look at how power relationships occur in health care systems (Waitzkin 1991) and how political issues such as poverty are transferred into illness categories because of hegemony (Sheper-Hughes and Lock 1987; Taussig 1980). Other critical medical anthropologies examine the ways resistance is acted out in illness representations through things such as somatization (Ong 1987). A critique of critical medical anthropology waged by Good (1994) is that local concepts of health, and the people who practice them, can get lost in the theorizing about the effects of hegemony on the population being discussed. However, since then Merrill Singer suggests an applied critical medical anthropology where medical anthropologists can go beyond academics and into health clinics, federal and international health organizations, and community health organizations (Singer 1995).

**Folk Illness as Inquiry**

Early medical anthropologies of folk illness in America focused on criticizing and critiquing biomedicine for the lack of understanding of the cultural aspects of illness and how people respond in culturally specific ways to illness (Clark 1959; Rubel 1960, 1964; Snow 1974). Subsequently anthropologists studied health internationally (Foster 1976; Kleinman et al. 1976; Leslie 1976). These studies contributed to a large body of work that shows that biomedicine is but one of many systems of medicine in the world. Studies by Fabrega and Silver (1973) and Fabrega (1975) have shown how biomedicine is different from folk medical belief, practice, and response. These early cross-cultural studies of health and health systems critique medicine in North America and Europe in general, and, more specifically, show a world-wide
trend toward bureaucratic professionalization in medical practices (Fabrega and Silver 1973; Fabrega 1975).

Afro-Caribbean folk medical knowledge comes from many experiences of health, disease, and healing and this knowledge has been shaped by ecology and history. Afro-Caribbean folk medicine occurs in response to several variables: the physical environment, specific diseases and how they are experienced, illness knowledge and cure, exposure to biomedicine, education level, and social class (Laguerre 1987). According to Laguerre (1987), there are three types of patients: those who only use folk medicine, those who use folk medicine as a last resort, and those who use folk medicine for minor problems and biomedicine for major problems.

Folk medical traditions are, according to Laguerre “the totality of health knowledge and medical practices of the Afro-Caribbean population which fall outside the mainstream medical system and are transmitted mainly by way of oral tradition from one generation to the next” (Ibid: 35). This knowledge can be transferred orally, through dreams, proverbs, or songs. In the Caribbean, folk healers are differentiated by religious affiliation, specialty, or both. Beckwith (1969) differentiates between Jamaican healers pointing out that there are Obeah1 and revivalist healers2, both use herbs and ritual in their healing, they have different faith, and thus, different healing practices. In Martinique, Horowitz (1967) found that folk healers are called curers and are differentiated by the types of herbal remedies they utilize, while in Guadalupe there are four categories of healer: curer, masseur, midwife, and magical healer (Laguerre 1987). Caribbean

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1 Obeah is similar to the Vodou practiced in Haiti. Obeah priest and priestess were prominent community leaders and teachers of African culture since slavery. Obeah priest and priestesses are know for their power when interacting in the supernatural realm. As well, they were the healer of choice for many people of African descent instead of a physician (Slave Resistance: A Caribbean Study. 2008)

2 Revivalist healers are spiritually based practitioners. They use stones, herbs, blood, and water as common elements in their healing repertoire (Payne-Jackson and Mervyne C Alleyne 2004).
healers attend to patients in their homes (Beckwith 1969), patients are serviced at the temple for supernatural illnesses (Métraux 1972), or patients may go to a healers home (Madam Tizo 2005).

There are two defining characteristics of Caribbean folk health knowledge. One is the categorization of illnesses and the other is the hot/cold dichotomy. In the Caribbean, there are personalistic and naturalistic categories to illness (Foster 1976; Coriel 1983; Laguerre 1987; McCarthy-Brown 2001). Foster (1976), argues that the personalistic illness category includes that magic, religion, and illnesses are inseparable and the naturalistic category includes the idea that disease has nothing to do with magic or religion. Disease is seen as belonging to natural, human, or spiritual origins. If it is a natural illness home remedies or a biomedical or folk healer will be used, and, if it is a supernatural illness a ritual or spiritual healer will be used (Foster 1976; Coriel 1983; Laguerre 1987; McCarthy-Brown 2001). As well, cures take the form of hot or cold where a cold illness must be cured with hot cures and vice versa (Foster 1976; Coriel 1983; Laguerre 1987; Brodwin 1996; McCarthy-Brown 2001).

The Haitian folk medical system has many of the characteristics of the Caribbean folk health system and is considered to mimic more closely its African roots in respect to folk medical traditions (Dutroit 2001). Thus, the hot/cold dichotomy, naturalistic, and personalistic illnesses are characteristic of folk health in Haiti (Coreil 1983; Laguerre 1984; Brodwin 1996; Dutroit 2001; McCarthy-Brown 2001). There are five kinds of healer: leaf doctor, midwife, bone setter, blood letter, and Vodou priest or priestess (Murray 1976; Coreil 1983; Laguerre 1987; Farmer 1988; Brodwin 1996; McCarthy-Brown 2001). Midwives and herbal healers are the most commonly used practitioners (Coreil 1983). Scholars writing on Haitian folk health use several different theoretical models of which to frame their research. These approaches are empiricism, interpretive anthropology, and critical medical anthropology.
Based within the empiricist tradition, where biomedicine is considered the norm, folk illnesses are questioned by Murray (1973; 1976; 1991) and considered psychological manifestations of the ways that people (mostly women) deal with biomedical dilemmas seemingly incurable with folk health methods, such as infertility and subfucundity. Other empiricists (Coreil et al. 1994) use epidemiology to identify at-risk people for folk illnesses in order to address those issues with Western science. These scholars contend, similar to Murray (1973; 1976; 1991), that a distinctly biomedical categorization for these illnesses can occur. Other scholars using an interpretive approach consider illness to be an explanatory model where the lived experiences of Haitian women are seen in the ways that folk illnesses manifest in their bodies. These folk illnesses have an etiology in stress, anger, and interpersonal strife that is experienced in the day-to-day life of these women (Farmer 1988). Singer et al. (1988), use a critical medical anthropological view to address folk health in Haiti. They contend that rural to urban movement raises accessibility to biomedicine which alters the ways that folk health is expressed. This process is considered by them to be a product of biomedical hegemony couched in the belief that these are illnesses shaped by historical, political, and economic factors.

Transnationality and the Nation-State: The Quest for Identity

This section presents the concepts of transnationalism as applied to Haitians living in the United States and the importance of identity to these peoples. Transnationalism is the set of social fields constructed by migrants within two or more countries. These social fields cross geographic, cultural, and political borders (Basch, Glick Schiller, and Szanton Blanc 1994; Glick Schiller and Fouron 2001). Transmigrants develop relationships—economic, political, familial, social, and religious—across national borders. Transnational movements are fluid, constantly shifting, and heterogeneous, making transnationality a complex topic (Chow 2003; Ifekwunigwe 2003; Lowe 2003; Duany 2004; and Sagás and Molina 2004).
Important to the idea of transnationalism and to the ways that Haitians are racialized is a discussion of the nation and the nation-state. These things—transmigration, the nation, and the nation-state— are connected because the transmigrant is constructed by and through economic and political reasons, and as well, through their identification with the nation-state. Current theories address the idea that the state transcends its borders and reaches out to a constituency of people whose ancestral homeland is within that state, yet, dwell within another state. A good example of the elasticity of state boundaries is in Haiti. In 1991, President Aristide was inaugurated and called the diaspora the “tenth department” (the Haitian government has nine departments). He asked for their help, power, economic and political interest, and interaction to continue supporting Haiti from abroad. Haiti, at this time, was an example of a deterritorialized nation-state. A deterritorialized nation-state exists when the state no longer recognizes constituents in its territory as the only constituency of the nation. The state extends its constituency to include those beyond its borders. Basch, Glick-Schiller, and Szanton Blanc (1994) suggest that the nation-state includes citizens whose geographic location is within other states, but these people politically, socially, culturally, and economically belong to their ancestor’s nation-state (Basch, Glick-Schiller, and Szanton Blanc 1994).

Identity is important to transmigrants because they struggle with dual associations. Who are these people? Do they identify as transnational peoples? Basch, Glick-Schiller, and Szanton Blanc (1994) write that most people have not formed transnational identities. And, in fact, there are rarely transnational states, communities, or individuals who identify as transnational (Basch, Glick-Schiller, and Szanton Blanc 1994). Transnational subjects have double or triple associations which are constantly undergoing negotiation. Economics, family and community relationships, and political and economic practices are the interstitial space that they must
negotiate in order to live between the nations of which they identify (Khan 1994; Ong 1999; Radhakrishnan 2003). In order to understand how identities are constructed in transnational contexts an explanation of Appadurai’s imagination and ethnoscapes frame how transnational peoples construct who they are.

For Appadurai (2003), the imagination is “an organized field of social practices, a form of work (both in the sense of labor and of culturally organized practice) and a form of negotiation between sites of agency (“individuals”) and globally defined fields of possibility” (Appadurai 2003: 30). Based upon Anderson’s (1991) use of imagination, Appadurai (2003) moves imagination out of the realm of the nation, the community, and geographic place and puts the imagination into a global context of imagined worlds (Kearney 1995). Imagined worlds are “the historically situated imaginations of persons or groups spread around the globe” (Appadurai 2003:31). Imagined worlds are important to transnational studies because they show the multi-dimensional global spaces people occupy (Ong 1999).

The building blocks to these imagined worlds are Appadurai’s (2003) landscapes. The landscapes, often called “scapes” by other scholars, constitute the global movements of people, technologies, media, finances, and ideas (Glick Schiller, Basch, and Szanton Blanc 1995; Kearney 1995; Glick Schiller and Fouron 2001; Stoller 2002). These scapes are the core of Appadurai’s (2003) model of global cultural flow. They are a “tentative formulation about the conditions under which current global flows occur: they occur in and through the growing disjunctures between ethnoscapes, technoscapes, finacescapes, mediascapes, and ideoscapes” (Appadurai 2003:35). This implies a reality that exits in the interstitial areas of people’s daily lives. It is at these interstices or narrow spaces between realities (which are constructed through interpretations gained from lived experiences) that a constant negotiation of what global reality is
occurs. Diasporic groups are within the interstices of global cultural flow because of an essentialized concept-bound border that places diasporic groups in between two societies. These borders are essentialized by the people who live within their geographic borders, and as well, they benefit from this essentialization of other “outside” groups. Appadurai (2003) writes of fissures and fragmentations between the movement of peoples, technologies, and financial flows which is linked to the idea of interstitial realities (Appadurai 2003). It is within the disjunctures between the scapes, as well as within the movement of the scapes themselves, that global cultural flow occurs.

Appadurai’s (1996; 2003) work puts forth a challenge to how we do our work and how we should think about culture, cultural flow, and globalization. Appadurai (1996; 2003) helps us see disjuncture between what appears to be and the reality of what is to be when applied to the formation of identity. Finally, Appadurai’s (1996; 2003) works show how globalization, rather then homogenize, is a complicated process that allows for diversity and in fact introduces diversity. However, Appaduari (2003) ignores the reality that nations and states are still bound together and his analysis of global cultural flow does not address issues of class, race, or gender giving the idea that all people have equal opportunities to mobility and to the different landscapes (Ong 1999). Relocation alters the ways that people live, view, and construct their lives which is seen in the importance of identities to transnational studies.

**Race and Ethnicity for Caribbean Transnationalists**

In this section, I reason that race and ethnicity become important factors to transnationalism because when people migrate they deal with a new set of ideas and practices surrounding these culturally-constructed categories (Basch, Glick Schiller, and Szanton Blanc 1994; Foner 2001; Vickerman 2001). Embedded in nationalism are ideas of race and ethnicity that construct the ways that transmigrants view themselves and are perceived in the host and
Race is important to Caribbean migrants to the United States because of the commonality across the Caribbean of African roots which make many migrants “Black” in the eyes of their new country. Ethnicity is important to Caribbean migrants because it is used as a way to distinguish groups of people. For instance, some Black migrants use their ethnic distinctions to separate themselves from African Americans. This occurs because African Americans are perceived to be at the bottom in Black American society in regards to cultural status (Harrison 1994). Therefore, it is better to be viewed as a foreign-born Black then a native-born Black person because of White oppression. In this way, ethnic distinctions are used by migrants in order to gain status in the United States.

The social and cultural meanings that humans have applied to phenotypic variations are cultural constructions however, in the United States, race is considered to be a biological fact. Although this is not accurate, race is a part of the dominant lived reality of many Americans and race as a cultural construction has real consequences faced by many. Race as defined by the American Anthropological Association is based within the idea that,

most physical variation, about 94%, lies within so-called racial groups. Conventional geographic "racial" groupings differ from one another only in about 6% of their genes. This means that there is greater variation within "racial" groups than between them. (www.aaanet.org 2008)

Glick Schiller and Fouron (1990) write that in the United States race cannot be considered lightly because, “race has emerged as a category critical to the maintenance of hegemony of the capitalist class and as such it takes on a profound reality”(Glick Schiller and Fouron 1990:332).

Race, and its emergence as a critical category in the United States, is important to this thesis because racism affects the ways in which people have access to health care. There is a racial order and health issues are affected by racial discourses. The New York City Department
of Health and Mental Hygiene states in a letter to New Yorkers at the beginning of a health disparities bulletin that, “while great gains have occurred in improving overall health and reducing health disparities, the persistence of racial, ethnic, economic, or other social inequalities in health is unacceptable” (Department of Mental Health and Hygiene 2004). The paragraph to New Yorkers finishes up by stating the ways the city can work towards eliminating these injustices and improve overall health care.

**Haitian Transmigrants**

Haitians are transmigrants because many develop and maintain relationships that occur across national boundaries. Current theories of transnationalism have focused on Haiti and Haitians (Glick Schiller and Fouron 1990; Glick Schilller et al. 1992; Basch, Glick-Schiller, and Szanton Blanc 1994; Laguerre 1997; Glick Schiller and Fouron 2001). For Laguerre (1997), the Haitian diaspora is displaced and reattached in a new place. This re-rooted life takes place in another state, but ties are kept with the homeland making them transnational citizens (Laguerre 1997). Thus the Haitian diasporic subject has a double allegiance to ancestral home and new home and lives within the tensions that interstitial life brings (Laguerre 1997; Duany 2004). This interstitial space can be an arena of resistance. “Within the social space of the dominant sector diasporic subjects are found or made to occupy a ‘minoritized space’ the locus of everyday resisting practices” (Laguerre 1997:31). Haitians send remittances (kept more regularly by women), keep up kin ties, and own business that operate in Haiti and the US (Laguerre 1997; 1984). Laguerre’s theoretical model depends upon center-periphery theory as its basis for how transmigrations occur. In this model the center includes geographic areas of Europe and North America and the periphery includes the countries where migrants come from, usually in the developing world (Laguerre 1997; Thomas-Hope 2003). In a similar vein to Laguerre (1997), Glick Schiller and Fouron (1990), Basch, Glick-Schiller, and Szanton Blanc (1994), Glick
Schilller et al. (1992), and Glick Schiller and Fouron (2001) address Haitian transnationalism and transnationalism in general and focus on a political economy approach. Political economy, in its most general form, refers to the intersection of people and societies in relationship to markets and the state. Political economy can reference health, migration, or any number of commodified aspects of society. For many transnational theorists this means that history, space, and identity politics must be analyzed to show their relationships to the global (re)structuring of capital (Szanton Blanc, Basch, and Glick Schiller 1995).

**Stigma as Discourse**

This section discusses stigma as a discourse because stigma causes life problems for the Haitian community. Discourse is the different ways in which we humans integrate language with non-language ‘stuff,’ such as different ways of thinking, acting, interacting, valuing, feeling, believing, and using symbols, tools, and objects in the right places and at the right times so as to enact and recognize different identities and activities, give the material world certain meanings, distribute social goods in a certain way, make certain sorts of meaningful connections in our experience, and privilege certain symbols and ways of knowing over others. (Gee 1996: 13)

Discourse “creates, recreates, focuses, modifies and transmits language” (Sherzer 1987: 295) and the subjective experiences of the Self. The Self is created through exchanges where the position of others is internalized and becomes how we view ourselves (Fife and Wright 2000). Stigma is discourse because it is characterized by social rejection, blame, internalized shame, and discrimination, which results from a judgment made about a person or a group being identified with a particular concern. Stigma is created, recreated, and modified by the ways that humans interact with language and non-language stuff. People participate in stigma producing behaviors and beliefs, write Phelan et.al (1997), “[because] those at the bottom of the economic heap are viewed as having arrived there because of their own shortcomings, responsibility is shifted from structural components of the stratification system to the individual, and the status quo is
legitimized” (Phelan et al. 1997: 325). This has to do with the use and role of power in the relationships between those creating stigma and those living it.

**Blackness and Disease**

Blackness becomes stigmatizing when it is used as a tool of discrimination. The subtleties of this type of discrimination are the driving force behind negative associations, in the case of Haitians, being linked negatively to AIDS and *Vodou*. Harrison (1998: 610) suggests, “racism assumes more subtle and elusive forms in the contemporary world, it is being reconfigured without ‘race’ as a classificatory device for demarcating difference.” An example of this is the negative associations made toward Haitians concerning AIDS and *Vodou*. Haitians are not the first people of African heritage to be considered vectors for disease in the United States. There is a long history in the United States of racism occurring in the form of targeting black bodies as unhealthy and blaming them for disease spread. In the early twentieth century, African Americans were targeted as carriers of hookworm, which was considered a disease of laziness in the South. Physicians thought Africans brought it from Africa and spread it throughout the United States (Wailoo 2006). African Americans in Baltimore were targeted when syphilis became known as a “black disease” because African Americans were considered to be unable to control their sexual instincts. Historically the United States has linked disease and Blackness, and, much like the Haitian AIDS situation, are examples of Goffman’s (1963) ideas of the stigma of race being linked to stigmatized disease. Goffman also addresses how categories of normal and abnormal reflect ideas about health and illness and are used to create difference between people who are “normal” and people who are “abnormal”. In 1932, a southern physician suggests that Black bodies are culturally abnormal because, “safeguarding of the health of the Negro [was not a] fight against disease, but against physical, mental, and moral inferiority, against ignorance and superstition, against poverty and filth.” (Wailoo 2006:531 quoting Miller

**HIV/AIDS and Vodou**

In the 1980s, Haitians were labeled as carriers of the AIDS virus by the Centers for Disease Control (CDC). In November 1981, medical authorities stated that newly arrived Haitians in Florida and New York showed characteristics of the yet unnamed disease. By July 1982, the CDC released information stating that 34 Haitians in the United States had characteristics of this new disease yet Haitians diagnosed with the disease denied using drugs or having homosexual sex (at the time, the only known “risk factors” for AIDS) (Farmer 2006). Haitian cases of AIDS confused the medical community because Haitians told health practitioners that they were not gay or IV drug users. This lead to an incorrect assumption that Haitians were a vector for AIDS and, subsequently, the medical establishment linked contraction of AIDS by Haitians to Vodou. Farmer (2006) writes that this occurred because of preexisting folk models that Americans had regarding Haitians. The Haitians, writes Farmer (2006), “fit the already established script: the incidence of AIDS in Haitians served to reinforce the stigma experienced by those with AIDS. For this to be so, there must have been strong, preexisting ‘folk models’ of Haitians” (Farmer 2006: 221). Information that supports his statement was plentiful during this time in the media. Images of filth, squalor, Vodou, and disease in Haiti flooded the papers. Further denigrating Vodou and its role in health, Dr. Jeffery Viera expressed to the New York Daily News that Vodou theoretically is related to AIDS. He stated, “references to voodoo were made in the context of a discussion of theoretical means of transmission of putative infectious agent among susceptible individuals” (Farmer 2006: 221). Viera also wrote that ‘magical rituals sometimes transfer blood and secretions from person to person. Women
have been known to add menstrual blood to the food and drink of partners to prevent them from ‘straying’” (Farmer 2006: 221). This sort of type-casting of Vodou as a religion of blood and ritual is a gross misrepresentation of the many types of ritual that are performed during ceremonies. This is an example of how a preexisting model of Vodou was invoked during this time.

Summary

Chapter 1 addressed how medical anthropology has progressed and changed methodologically and theoretically since its inception. Ruth Benedict’s work in anthropology helped frame medical anthropological inquiry when she began to question medical definitions scrutinizing the biomedical system. Folk medical inquiry in anthropology has lead to a larger understanding of the different ways of knowing and the correlating systems of medicine to that knowing that exist in the world. The Haitians of this research are transmigrants who bring their folk medical methods and theories with them to the United States. Their status as transnationalists, and the identities they construct because of this, is directly linked to the ways they utilize and experience medicine and health.

Chapter 2 on the background and history describes a political history of Haiti and how United States interventions and policies affect Haiti and Haitians. Demographic information about Haitians in Haiti followed by a brief overview of Haitian migration contextualizes the Haitian experience in New York. Demographic information about Haitians in New York City in general, and Central Brooklyn more specifically allows for a comparison of the general standard of living faced by migrants when they arrive in the United States.

Chapter 3 presents survey data from Haitian subjects and health care workers. All surveys occurred in public places throughout the East Flatbush community. A basic history about East
Flatbush, methods and sampling design, sampling issues and a description of the research sites occurs.

Chapter 4 presents a range of twelve illness concepts and categories used by Haitians in Brooklyn. Categories were chosen because they were addressed by the public health advocacy community or because they were folk illnesses that are used to explain pathologies related to reproductive health issues. In this section it becomes clear that women use folk health categories to avoid inter-group stigma, but are faced with stigma from health practitioners in regards to their belief in folk concepts of health.

Chapter 5 presents and analyzes the data from the interviews in the form of case examples. There are four narratives divided into two sets because two of the narratives address the issues of AIDS, Vodou, and Blackness while the other two narratives address people’s experiences and reflections on folk health illnesses.

Chapter 6, the conclusion and findings, shows how race and religion, and people’s experiences with health and healthcare reflect one another and shows how women use folk illness categories to lessen the stigma associated with barrenness and related reproductive health issues.
CHAPTER 2
HISTORY AND BACKGROUND

Introduction

This chapter contextualizes the Haitian experience through a brief political history of Haiti, basic demographic information about Haitians in Haiti, and peak periods of Haitian migration that coincide with periods of political instability. The United States government and military were involved through an occupation from 1915-1934, by backing Duvalier for president in 1957, and by not supporting Jean Betrand Aristide, a democratically elected president. These years, 1915-1934, 1957-1971, and 1972-1994, were not only plagued by political instability in Haiti, but were important political times for Haitians in the United States. Haitians were labeled as AIDS vectors, and the FDA banned Haitians from donating blood, which led to protests in Miami and New York. These protests helped to end the ban against Haitians donating blood.

Haitians in New York have not managed to escape politics or poverty. They live in overcrowded households and have higher-than-average health indicators such as death rate and instances of HIV and AIDS. Statistics on reproductive health in Brooklyn and Central Brooklyn do not fare better. In Brooklyn, health indicators such as infant mortality rate and maternal mortality rate are higher than for New York City as a whole.

An important aspect to Haitian health and healthcare is Vodou. This complex relationship means that Haitians have multiple ways of understanding and participating in healthcare interactions. Therefore, Vodou and folk medical practices are connected through belief and practice. There are specific folk illnesses that only a Vodou priest can heal. These illnesses are believed to be created by the Haitian lwa or spirits that are worshipped in Vodou.
Haiti: The First Independent Black Republic

Haiti was declared independent by Jean-Jacques Dessalines who took over the Black army after Toussaint, then leader of the Black army, was taken captive. This marked the end of the only successful slave revolt in the history of the world and the first Black nation to win independence. The victory was bitter-sweet as it resulted in Haiti struggling internally and being ostracized from the global political society. This was a time of isolation for the country. Further neglect from outside sources occurred when Dessaline was named Emperor and liquidated the French who still resided on the island. Battles with the French and Spanish army splintered Haiti. Outside of Haiti, the United States, France, and Britain took notice of the internal struggles occurring in Haiti. Although the Congress of Vienna abolished the African slave trade, the world was not yet ready to recognize a nation whose insurrection was led by a slave revolt. The United States position with Haiti was split—Northern merchants wanted to trade with Haiti, but Southern slave owners did not (Heinl and Heinl 1996). United States support of Haiti began as early as 1803, when arms were shipped to aid Dessaline even though President Jefferson, at the behest of Napoleon, had placed an embargo against Haiti from 1806 to 1809.

When the Americans decided to occupy Haiti in 1915, the country had gone through its eighth brutal overthrow of government in less then seven years (Heinl and Heinl 1996). In fact, of the twenty-two leaders between 1843 through 1915, “only one had served out his term of office. Four had died in office. One had been blown up in his palace. One had been overthrown and executed. One had been torn to pieces by his subjects. Thirteen had been ousted by coup or revolution” (Heinl and Heinl 1996: 385). Thus, the occupation began. Jean Dominique, an outspoken radical Haitian journalist, references his memories of this time in Haitian history when political decisions on behalf of Haiti began to be decided by, or were highly influenced by, the United States marines and government.
I was 4, 4 years old when the Marine left Haiti, the US marine left Haiti, I was a kid, and every time a Marine battalion passed in front of the house my father took my hand and said, “don’t look at them...don’t look at them”. And every May 18th which is the Flag Day, defiantly, he put the Haitian flag in front of the house and I said, “father what is that, what does that mean for you?” He said, “that mean that you are Haitian. That mean that my great grandfather fought adversity never forget that”. You are Haitian. You are from this land. You are not French. You are not British. You are not American. You are Haitian. (Wyclef Jean 2004)

This political decision-making plagued by paternalistic attitudes from the United States has continued to the present day through the most recent elections. This quote speaks to the frustration that was felt by many Haitians during this occupation of their country. The line where Dominique’s father reminds him that he is not French, British, or American speaks to all of the different colonial influences that have at one time or another intervened in the politics, economy, and society in Haiti. Dominique’s father did not want him to get lost in those other identities, but wanted him to continue to identify as “proud to be Haitian” especially in the midst of an American occupation.

1915 through 1934

From 1915 to 1934, the United States Marines occupied Haiti in response to the instability that plagued the state. The United States identified three tasks in Haiti: to create political stability, to control Haiti in regard to United States interests in the Caribbean, and to integrate Haiti into the global capitalist economy (Renda 2001). When the United States Captains arrived in Haiti, they addressed those in power and explained that they would choose the next leaders, and, would institute pseudo-elections to hide this fact. Before the election, the United States informed Haitian congress that they would take control over customs and financial affairs in Haiti as they deemed necessary. The political agenda of the United States in Haiti was large in scope and included a decision by the marines to dictate culture as well as state function. The United States marines instituted a law which prohibited the practice of Vodou (Renda 2001).
The marines burned drums and other *Vodou* related articles and ceremonies were prohibited. This behavior paved the way for the early 1940 antisuperstition campaigns where the Haitian clergy, local missionaries, and President Lescot destroyed and burned *Vodou* temples, drums, and other artifacts. Other oppressive and paternalistic acts the United States committed while in Haiti—investments in fruit, sugar, transportation, and banking which used forced labor gangs of Haitians to promote this modernization. The forced labor system was brutal and many marines acted with racist tendencies. A main aspect of the militarism at this time was its racist paternalism which was a part of United States foreign policy (Renda 2001). The marines considered Haiti and Haitians to be wards of the United States, Renda 2001 writes, “Indeed, over the course of the occupation paternalist discourse constructed Haiti as a nation orphaned by parental neglect, sometimes figuring France as the father who abandoned Haiti and Africa as the single mother incapable of raising her illegitimate child alone” (Renda 2001: 16). Because of racist attitudes, forced labor, and other complex interactions frustration with the occupation began to build (Renda 2001; Arthur 2004). In 1934 the United States left Haiti.

**1957 through 1986**

After years of independence from the United States, in 1957 elections occurred in Haiti with the United States supported François Duvalier (Heinl and Heinl 1996; Arthur 2004). Duvalier won the election. This election was considered to be corrupt and was contested by many (Heinl and Heinl 1996). The early 1960s, was the most oppressive and terror-filled time of the Duvalier family rule. In 1971, Papa Doc Duvalier died and his son, Jean-Claude Duvalier or Baby Doc, took over as “president for life.” Baby Doc was just a figure-head for the first few years because of his age, but during his time he had built up Haiti as a place for tourism. In 1982, when the Centers for Disease Control (CDC) linked Haitians to AIDS, tourism in Haiti declined (CDC 1982a and 1982b). By 1983, newly immigrated Haitians to the United States
became labeled by the CDC as a “high risk group” for AIDS (CDC 1982b). The effect was
catastrophic in both Haiti and the US. By 1983, the tourist industry in Haiti floundered and
failed (Heinl and Heinl 1996). During the summer of 1983, Haitians were taken off the New
York City’s Public Health Department’s list of a high risk group for AIDS because of the high
levels of discrimination toward Haitians in the city. In April 1985, the CDC removed Haitians
from their high risk group list (Farmer 2006). However, tourism never recovered and Americans
never forgot this distinction. In 1986, a popular uprising that began in the Northern city of
Gonaïves, overthrew Baby Doc in what Haitians called Dechoukaj (to uproot) (Heinl and Heinl

1990 Through 1994

In 1990, two things happened. The United States made changes in their health policies
toward Haitians and Haiti elected a new president. Haitians in the United States had long
struggled with racist policies by the Centers for Disease Control (CDC) which declared their
health status as AIDS vectors, and, policies by the Food and Drug Administration (FDA) which
disallowed Haitians who migrated to the US after 1977, from donating blood (CDC 1982b and
Farmer 2006). This policy changed on February 5, 1990, when the FDA banned all Haitians
from donating blood. The FDA defended their decision stating that with Haitians HIV/AIDS is
transported mainly through heterosexual sex, and, because of this, they had no good screening
methods of which to locate Haitians who were at high risk for HIV/AIDS (Farmer 2006).

Haitians renamed the FDA to the “Federal Discrimination Agency” which was seen on
placards that were held by some protestors, about 5,000, in Miami that March (Farmer 2006).
This movement by Haitians in cities across the US began to grow rather then subside and on
April 20, 1990, fifty thousand protestors supported by Mayor Dinkins and the Reverend Jesse
Jackson marched across the Brooklyn Bridge closing the bridge to traffic for the day (Farmer
The Haitian press commented that numbers this large of a sea of black faces had not been seen in New York since Martin Luther King’s funeral in 1968. The FDA responded to this protest by forming an advisory panel, which called for an end to blood donor bans based within nationality and geography (Farmer 2006) which in December of 1990, was enacted and the ban against Haitian blood removed. Alongside the political struggles that Haitians were having in the United States Haitians in Haiti were affecting political and national growth. Jean Betrand Aristide, a catholic priest deeply connected to the Haitian people, ran for president.

In 1990, Jean-Betrand Aristide became the first democratically elected president of Haiti by a 67% majority. Aristide brought hope to the people who began to come together and tried to better their communities through community service. Aristide, they thought, would bring positive change to Haiti. However, Aristide was not supported by the United States government (Heinl and Heinl 1996; Arthur 2004) or Haitian elites, and so in 1991, the Haitian army ruled by General Cédras, took over the country in a coup d’ etat. The Cédras government ruled under a reign of terror surpassing the violence and political oppression of Duvalier in the early 1960’s (Heinl and Heinl 1996). Arthur writes, “For three years, summary executions, arbitrary searches and arrests, disappearances, beatings, torture, and extortion were systematic and commonplace” (Arthur 2004:25). This regime was supported by the Front for Haitian Advancement and Progress (FRAPH) and by the CIA, although this funding was unofficial (Bell 2001). Bell writes of some of the atrocities experienced by Haitians during this time. She writes, “A common tactic of FRAPH members –themselves largely recruited from slums and villages—was to slice off the faces of their victims before depositing them in open-field garbage dumps in Cité Soleil” (Bell 2001:13).
In 1994, 20,000 United States troops arrived in Haiti and Aristide was restored to presidency by the United States government under President Clinton to finish his five-year term. René Préval acted as president in 1996, as a part of Aristide’s Lavalas “Cleansing rain” party. In 2000, Aristide was elected again (USA Today 2006), but was removed, in 2004. The United States marines took Aristide and his family to a plane and forced him to leave the country (BBC 2004a and 2004b). Until present day, the United States contends that Aristide requested to leave, but Aristide insists he was kidnapped (BBC 2004a and 2004b). Gerard Latourtue, the new US appointed Prime Minister began his very short term. CARICOM (Caribbean Community Secretariat) and 22 members of the Congressional Black Caucus all refused to recognize Latourtue (Edwards 2004).

Haiti: The Poorest Country in the Western Hemisphere

Haiti is the poorest country in the Western Hemisphere (Loescher and Scanlan 1984; Stepick and Portes 1986; Lennox 1993; CIA World Factbook 2006). This is one of the most commonly written references about Haiti as if the complexities that have created Haiti’s economic, political, and cultural position can be summed up in this one statement. Haiti is a little smaller than the state of Maryland and located on the Western 1/3 of the island of Hispaniola which it shares with the Dominican Republic. Due to major soil erosion, only 28% of land is arable (CIA World Factbook 2006). Deforestation is a major issue as trees are used for fuel and cleared for agriculture and most of the country does not have access to potable water (Lennox 1993; Arthur 2004; and CIA World Factbook 2006) which all, along with historical and political occurrences, contribute to Haiti’s poverty.

Haiti’s population is about 8,308,504 (CIA World Factbook 2006), with the median age at 18.2 years. Ninety-five percent of the population descends from Africa while 5% is biracial, Caucasian, and of other descent. The average life expectancy is 53 years and the HIV/AIDS
prevalence rate among adults is 5.6%. There are 36.4 births per 1,000 women and an infant mortality rate of 71.7 deaths per 1,000 live births (CIA World Factbook 2006). Inadequate nutrition and sanitation leaves Haitians in poor health. Thirteen percent of Haitian children die before the age of five and one-fourth of Haitians die before the age of forty (Arthur 2004).

Roughly half of Haiti’s children do not attend school due to lack of access to affordable schools. There are few free state-funded schools (less than 100 in the entire country) as most are run by mission groups and are private. The typical cost of tuition is $US40 per year which is 16% of the average annual income of $US250 (Arthur 2004). Haitian education is based upon the French system and includes seven years of primary education and seven years of secondary education (Building with Books 2004). When students finish primary school, they receive a primary education certificate and may then take exams to enter a lycée (public school) or a collège (private school) (SAGART Design 2006). Secondary education has a lower-level cycle that lasts three years and a higher level cycle that lasts four years. After completion of the first three years, a student is awarded a baccalauréat. In the higher-level cycle, receiving a classe de philosophie, which is a part of the baccalauréat, allows potential candidates to be able to attend college (SAGART Design 2006). Forty-eight percent of the population is illiterate (CIA World Factbook 2006). More than 60% of urban males in Haiti are unemployed, while women are afforded more job opportunities. Given the political and economic adversity faced by many it is not surprising that Haitians who are given the opportunity to leave Haiti migrate.

Haitian Migration to the USA

The objective of this section is to show migrations patterns of Haitians to the United States. There are three peak times that Haitian migration to the United States occurred. These

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1 This is because of a gendered division of labor imposed by outside companies who perceive woman to be better at piecework and by internal divisions of labor where woman are considered to be better at commerce.
were during the 1915-1934 occupation of Haiti by the US, 1957-1971 when Duvalier was in power, and 1972-1994 during Baby Doc’s term and the post Duvalier political aftermath (Lennox 1993; Laguerre 1997). Labor migrations from the Caribbean have taken place for the last 500 years; however, Haiti has not followed this pattern (Stepick and Portes 1986). Haitian migrants first began to arrive in the USA between 1791 and 1809 (Lennox 1993; Laguerre 1997) during the French and Haitian revolutions in low numbers. In attempts to stifle Haitian migration to the United States during this time fugitive slave legislation was implemented (Lennox 1993). This applied to Haitians because, although most Haitians were free by Haitian law, they did not have proof of this freedom (Lennox 1993).

United States involvement in Haiti has contributed to Haiti’s current political, economic, and cultural situation. Historically, the United States dominated Haitian affairs while seeking hegemony over the Caribbean region (Lennox 1993). This was achieved through governance over Haitian import markets, investment in railways, and in 1910, the US gained control over the Haitian banking system (Renda 2001). In 1915, the United States staged an election which installed the first client-president who was hand picked by the United States (Lennox 1993). From 1915 to 1929, over half a million Haitians left Haiti, some as labor migrants to the cane industries in Cuba and the Dominican Republic (Arthur and Dash 1999). When the United States occupied Haiti, they were also occupying the Dominican Republic from 1916-1925 and American owned sugar companies used Haitian labor in both countries (Arthur and Dash 1999). During the United States occupation of Haiti, the United States implemented segregation policies between White Americans and Black Haitians and encouraged United States businesses to exploit the few resources available in Haiti (Lennox 1993). The United States was partially successful in creating infrastructure such as roads, hospitals, and schools, but when the United
States left in 1934 the nation was economically crippled (Lennox 1993), However, Laguerre (1997), notes that as soon as the United States Marines left Haiti, the infrastructure they had built began to crumble.

The second peak era of Haitian migration was from 1957 through 1971, when Duvalier was president. Duvalier was elected with Haitian military backing in 1957 and by the early 1960s large numbers of Haitian migrants began arriving in the United States (Loescher and Scanlan 1984; Laguerre 1984; 1997; Lennox 1993; Arthur 2004). From 1956 to 1986, one million US visas were given to Haitians with half of these people over-staying their visas. The Duvalier era was characterized by migration, creating a middle-class in Haiti that survived on remittances from Haitians in the United States (Laguerre 1997), which were roughly 25% of the GDP in 2005 (CIA World Fact Book 2005). Those who migrated were mostly government officials, politicians, and professionals who had limited or no economic opportunities under Duvalier. Duvalier formed the *Tonton Macoutes*\(^2\) a secret police or private militia. This police force helped Duvalier to impose indiscriminate violence against all real and imagined opposition to his regime (Arthur 2004). Roughly 30,000 opponents of Duvalier were killed and the United States continued to support the regime. Duvalier was favored by many US presidents, including Eisenhower and Johnson. Duvalier’s violent oppression was ignored and aid flowed freely to this corrupt government, with the United States supplying about 20 million in aid from 1946 through 1972 (Loescher and Scanlan 1984). Duvalier was able to hold favor of the US through political tactics such as his denunciation of communism, which, linked his government to the US rather then to Cuba.

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\(^2\) *Tonton Macoute* literally means Uncle Sack. Uncle Sack is a person who comes around at night and puts bad children into his sack and steals away into the night.
After Papa Doc Duvalier’s death in 1971 a second wave of Haitian migration occurred (Lennox 1993 and Laguerre 1997). Lennox (1993) writes that, “Between 1972 and 1980, approximately 50,000 Haitians attempted to gain asylum in the United States; as few as 25 succeeded” (Lennox 1993: 700). The United States was able to refuse large numbers of people through interdiction at sea, deportation, and detention. Accelerated deportation occurred by the INS asking immigrant judges to see, rather than the normal one case per day, up to 50 cases per day (Lennox 1993). Interdiction at sea occurred formally during the Reagan administration. Reagan claimed that too many refugees posed a threat to United States interests and gave aid packages to Baby Doc in exchange for his support of the interdiction program. The United States rationalized their restrictions on Haitian immigration by stating that Haitians are economic rather than political refugees. During this time in Haitian history, an exodus from Haiti began that came to be known as the “Haitian Boat People.”

In 1972, the Haitian Boat People began to arrive on the shores of Florida, some dead and some alive. They arrived in small to medium-sized vessels that were over-loaded with people. Life on the boat was extremely difficult and many did not make it. On some boat trips the people ran out of water and food well before they arrived in the United States, and many died at this stage (Stepick 1982). Sometimes the boats capsized and people drowned before the trip was over. The people in these boats could not afford exit visas or plane tickets, but sold all of their land and belongings to board the rickety ships (Arthur and Dash 1999). Throughout the 1970s, about 50,000-80,000 people arrived in Florida this way. Until 1981, when interdiction began, the boat people were detained in Florida and deported as quickly as possible. Since 1981, they have been returned directly to Haiti without opportunity to request asylum (Mitchell 1994). This policy is challenged by many who believe it is inhumane and is based on discrimination.
However, the United States has the legal ability to uphold their interdiction policy of Haitians (Mitchell 1994). Although the boat people were arriving in desperation on US shores, monetary support to the Haitian government continued.

There are several economic reasons why the United States should not have given monetary and political support to the Duvalier government. Loescher and Scanlan (1984) note that, “In 1978, the Congressional Research Service estimated that 50% of Haiti’s income was in unbudgeted accounts that were presumed to end up in private hands” (1984: 317). A 1979 World Bank report stated that in 1977, 40% of all Haitian government costs and income were channeled through special accounts with the National Bank so that it was difficult to know where the monies came from or where they went (Loescher and Scanlan 1984). In 1986, a mass of people rose up to dechouka the Duvalier family from their place of power.

**Haitians in New York**

Haitians rank 18th for those living in the United States who are foreign born. There are 419,317 Haitians in the United States and Haitians account for 95,580 of New Yorkers (Burden 2000). These figures do not take into account illegal migrants. Laguerre (1984) writes that Haitians regard each borough through the eyes of economic class. For instance, middle-class Haitians reside in Manhattan, upper-class Haitians reside in Queens, and lower-class Haitians reside in Brooklyn (Laguerre 1984). The top three neighborhoods in Brooklyn where Haitians reside are: Central Flatbush of which 15.5 % are Haitian, Flatlands-Carnarsie of which 12.1 % are Haitian, and Crown Heights of which 8 % are Haitian (Burden 2000).

Socio-demographic characteristics such as age distribution, family type, average size of household, English language proficiency and education, and household income give a more complete idea of the lives of Haitians in New York. In general, immigrants to New York are 18-
65 years of age. Haitians fit this statistic with 48.8% between the ages of 18-44, 31.5% are between the ages of 45-64, and 12.6% of Haitian migrants are 65 and over (Burden 2000).

A family household, as defined by the census, is any group of people living together in a home or apartment, who are related (Burden 2000). Out of 40,694 Haitian households, the average number of people per household is 3.5 which is higher than the city-wide average of 2.6. However, it is common for foreign-born households to be larger than native-born households. Out of these households, 30.2% are owner occupied, and 26.4% are overcrowded.

Overcrowding is defined by federal standards as occurring when there is more than one person per room (Burden 2000).

Seventy-one percent of the Haitian population in New York above the age of five is not proficient in English. Thirty-one percent of Haitians have had less than a high school education, while 25.8% are high school graduates, and 16% have had some college or more (Burden 2000). Haitians who migrate to the United States have higher education levels than most Haitians in Haiti, but lower education levels than people who were born in the United States (Lennox 1993). The median household income of Haitians in New York is $36,000. Out of 96,032 Haitians, 19.1% of Haitians are in poverty3 and out of 40,694 Haitian households, 5.9% are on public assistance (Burden 2000). Statistics for Haitian health in Central Brooklyn reflects the general poverty conditions as described above that people endure.

The overall death rate in Central Brooklyn is 20% higher than all of Brooklyn and 30% higher than New York City. People living with HIV and AIDS is about 35% in Central Brooklyn while in the last year residents are more likely than New York City as a whole to get an HIV/AIDS test they are less likely to use a condom (New York City Department of Mental

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3 The poverty level is a federal standard. This refers to households of four with an income of $16,665 per year or below (Burden 2000).
Reproductive Health in Central Brooklyn, United States, and Haiti

Women are more likely to be screened for cervical cancer and less likely to have a mammogram in Central Brooklyn than in all of New York City while people are less likely to be screened for colon cancer (New York City Department of Mental Health and Hygiene 2008). Thirty-five percent of women in Central Brooklyn are more likely to receive late or no prenatal care while in New York City in general 28% of women receive late or no pre-natal care. Maternal and child health in Central Brooklyn rates in the bottom 10 New York City neighborhoods out of 41 neighborhoods being compared (Department of Mental Health and Hygiene 2003). The fertility rate in Brooklyn is 68 per 1000 with a population of 2,465,326 compared with NYC as a whole which is 66 per 1000 with a population of 8,008,278. Infant mortality rate (IMR) in Brooklyn is 6.6 while it is 6.1 for all of New York City with only the Bronx having a higher IMR at 7.1 (New York City Department of Mental Health and Hygiene 2004). The maternal mortality rate for Brooklyn in 2006 was 34.7 per one-thousand births compared to all of New York City’s rates of 29.3 (Personal Communication, Richard Genovese, NYC Department of Health 2009).

In the United States in general the infant mortality rate is 6.3 per one-thousand with 14.18 live births per one-hundred thousand with a total fertility of 2.1 children born to each woman and the maternal mortality is 14 per one-hundred thousand (CIA World Factbook 2008). While in Haiti there are thirty-five live births per one-thousand with the infant mortality rate at sixty two per one-thousand and a total fertility rate of about 5 children born to each woman (2008 World Health and Hygiene 2008). Twenty-nine percent of residents do not have a primary care physician while 21% of residents are uninsured and 66% of residents have been insured for at least one year. Twelve percent of adults in Central Brooklyn have diabetes compared to 9% in New York City as a whole.
Fact Book). The maternal mortality rate in Haiti is six-hundred eighty per one-hundred thousand (World Health Organization 2006).

**Healing Role of Vodou**

*Vodou*, health, and healing form a complex relationship which is important to understanding folk illness concepts and practices in Haiti, and with Haitians in the United States. *Ekspedisyon* (sent sickness) is an etiological category that can be applied to a range of illnesses both biomedical and Haitian folk-based illnesses. A sent sickness is sent through ritual created by an *oungan* or *mambo* (*Vodou* priest or priestess). Magical illness or spirit-based illnesses are magical at their point of causation and are sent by the *lwa*. This means only the *lwa* can cause this type of illness and it is magic because the *lwa* and God are supernatural beings. Farmer (1990) found that when informants discussed magical illnesses some linked this to *Vodou* while others (both Protestant and Catholic) did not make this distinction (Farmer 1990). He suggests that the links to *Vodou* concerning sent and magical illness are unclear. However, in the canon on *Vodou*, there is discussion of *Vodou* as a part of the healing system in Haiti (Laguerre 1984). Folk illnesses are known, in some cases, to be caused by supernatural entities (Murray 1991; McCarthy-Brown 2001).

In *Vodou*, there is God or Lord (*Bondye* or *Grannèt*). *Bondye* created the spirits (*lwa*) that exist in *Vodou* (Murray 1991 and Desmangles 1992). The *lwa* may correspond to Catholic Saints and often draw upon West African prototypes. Murray (1991) gives an excellent example of how *bondye* and the *lwa* are regarded within *Vodou* cosmology.

Only he can create rain, for example. Once the rain clouds are there the loua can mischievously move the clouds around to help or punish someone; and they can tie up the rain to prevent it from falling. But they are powerless to create rain. Only Bondye has that power… Most importantly for this discussion, only Bondye can create *life in the womb of a woman.* (Murray 1991:9)
There are types of lwa such as family lwa that are adopted by each family. The lwa can be used for positive and negative purposes. A lwa can mount a person through spirit possession or a person can purchase a lwa making it do whatever is asked (Herskovits 1937). The priests and priestesses in Vodou are called Oungan and Mambo respectively (Murray 1991; Desmangles 1992; Desrosiers and St. Fleurose 2002). These ritual practitioners oversee ceremonies and perform spiritual healing rights. There is also a third ritual practitioner called a bòkò. A bòkò is a sorcerer or priest who deals in malevolent magic (Herskovits 1937; Desmangles 1992; Desrosiers and St. Fleurose 2002). Some folk illnesses are known to be caused by Vodou alone while other folk and biomedically based illnesses can have various etiologies that include Vodou.

Summary

This chapter describes Haitian and United States political history. Demographic information about Haitians in Haiti and their migration to the United States is overviewed and demographic information about Haiti and in New York and central Brooklyn is addressed in order for a more complete picture of Haitian migrants in the New York to emerge.
CHAPTER 3
METHODS

Introduction

This chapter describes the research area and field site locations as well as methods and sampling design. East Flatbush is located in Central Brooklyn one of the five boroughs in New York City. Methods used were typical for anthropological inquiry and included participant observation, open-ended interviews, and surveys. The sample size included 27 structured interviews with Haitian informants, 27 surveys with health care workers in the community, and four in-depth interviews with Haitian informants.

Some sampling issue were my racial and outsider status, however after daily visits people began to trust me. The research sites were varied and included local health care facilities and non-profits, a local Caribbean market, and a health fair. Data were collected from these sites after one month of observation and time spent learning about the community and making contacts within the community.

East Flatbush

The community of East Flatbush is located in Central Brooklyn bounded to the East by Utica Avenue, the North by the Eastern Parkway, to the South by Flatbush Avenue, and the West by Ocean Avenue which runs along Prospect Park (Boundaries of the Brooklyn Community Districts 2004). These are rough boundaries. For instance different New York City government agencies site slightly different areas for this neighborhood and the people who live there also have different boundaries for their community then the city. When exiting at the Church street subway stop the street is lined with Haitian, Jamaican, Trinidadian, Guyanese, and fast food restaurants. The smells of baking chicken and sweets fill the air. Walking West toward Flatbush Avenue, there are at least three money transfer businesses that advertise in Creole and are
adorned with the Jamaican flag. There are Haitian women who sell peanuts, perfume, and spices along the street and older men who hang out drinking sodas, socializing. The foot and motor vehicle traffic on these main streets is heavy with lighter traffic on the residential cross streets.

Apartment complexes in this neighborhood stand anywhere from 4 to 15 stories with a few ranch style houses sprinkled in among the urban architecture. One apartment I visited in this neighborhood was a clear indicator of the poverty level. The hallway had large chunks of tile missing, and while I was visiting, the apartment and hallway flooded with more than an inch of water and we lost electricity for about 2 hours due to the flooding. Everyone was calm; we continued to play cards (although we took it outside) while another member of the building temporarily stopped the flooding and returned the electricity. The residential areas, at least in the summer, are teeming with people, children running around and eating ice cream, people playing dominoes or cards at tables, and women having casual conversations in corner stores.

**Methods and Sampling Design**

The relevance of the previous section concerning the background of East Flatbush is that a general description of the neighborhood and housing available create a structure of which to construct and further analyze the research area. My methods included participant observation, open-ended interviews, and surveys. I collected pamphlets and flyers that were handed out in the neighborhood and at health events and clinics and took photographs in order to contextualize the community of East Flatbush and the Haitian events that took place outside of this neighborhood.

The original field plan called for work with obstetric nurses and doctors who served the Haitian community and Haitian women of different ages. I soon realized that my field plan and research had to be altered. First, access to obstetric doctors and nurses was difficult because I did not have any connections to this community. Second, it seemed necessary to speak with both men and women about the illnesses in question. The revised research plan considered two
distinct groups and the variables were more general. Health workers who served the Haitian community and Haitian subjects, both men and women, were included in the new research. All interviews took place in a public place. The same structured interview was used for men and women, but questions about the menstrual cycle were omitted for male interviewees. I had the advantage of speaking Haitian Creole and English—two of the three languages, Haitian Creole, English, and French, spoken in the Haitian community in the United States. Most interviews and surveys occurred in Haitian Creole except when an informant requested English to be used.

The final sample size was twenty-seven structured interviews from Haitian subjects1, twenty-seven questionnaires from health workers, and five structured interviews. However, the final data I drew upon includes ten Haitian subjects, twenty-six health workers, and four structured interviews. I chose to leave out 17 of the questionnaires with Haitian subjects because I asked baseline data and asked about use of teas, but omitted questions concerning folk health illnesses. The following questionnaires were omitted: eleven collected from Kreyòlfest, 3 collected from the Caton Flatbush market, 1 collected from the Linden Medical clinic, and 2 from CWHA. These questions were omitted as they were not giving me the type of information I wanted, nor did they lead into conversations about the health concepts I wanted to address.

Table 3.1 shows the distribution of the sample collected across seven locations.

**Sampling Issues**

The first issue was my racial and outsider status in the eyes of the community. This became clear when an informant Lamèsi told another woman Mikerlin that, “she is not a racist. You can talk with her.” Although this comment was made, I still found it difficult to gain the trust of the women in the market. However, after daily visits, by the time I was finished with my

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1 When I use the term Haitian subjects this refers to the men and women who were not health workers, but were patients at the Linden Medical Clinic and marketers at the Caton Flatbush market.
research; people in the market had become more comfortable with me. Second, was my lack of familiarity with the informants. Farmer (1988) and Chen and Murray (1976) write that familiarity with Haitians in particular is an important factor to collecting dependable information when compared with other groups with whom they had conducted research. This is true for the studies they had conducted with at that time and may not be true for all groups of Haitians and all studies with Haitians.

I found this to be an issue in my research even after 3 months of daily visits and one year of occasional visits. In my later visits during the initial summer research people became more comfortable with me and became a bit more open in their discussions. After one year when I returned to do more interviews informants were much more comfortable with me and I found that they were more willing to share information.

The Research Sites

My second day in New York I headed to Brooklyn to make appointments with some of the Haitian non-profits I had previously researched. I intended to create an affiliation with a non-profit so that I could access the Haitian community in this way. Although I did not create an affiliation with my first nor second choice, my first choice was in the process of moving, and my second choice never contacted me, however, the third non-profit proved to be my way into the community. At the Caribbean Women’s Health Association (CWHA) I spoke with the executive director and was awarded an intern position which began the following Monday. Figure 3.1 is a map of the general research area and each individual research site is shown by a yellow thumbtack on the map. Table 3.1 shows the distribution of the sample broken down by number of questionnaires completed.

The Caribbean Women’s Health Association (CWHA), located on Linden Boulevard in East Flatbush, services the Caribbean community by offering a range of health services that
include, but are not limited to, adolescent health, perinatal and prenatal health outreach, 
HIV/AIDS outreach, and Asthma outreach. I was one of two people at the office who were not 
of Caribbean descent. However, people were welcoming and interested in my research. 
Through colleagues at CWHA, I was able to make contacts with Haitian subjects in the general 
community. CWHA seemed typical of many non-profits in this community. There were always 
clients flooding the hallways, waiting for a meeting. They sat on metal chairs and were cooled 
by the one large fan provided for the entire area. Offices were small and everything from Rapid 
HIV/AIDS tests to the filling out of immigration papers occurred within their walls. Needless to 
say the diversity of New York City was very much alive inside CWHA as lively discussions in at 
least four languages, Creole, French, English, and Spanish occurred between clients and between 
staff and clients in the hallways. Through my affiliation at CWHA I was able to gain access to 
other non-profits and health clinics in the area.

The Caribbean American Center is a sister nonprofit to CWHA, Lutheran Families, and 
Partners in Health. It is one of many clinics that serve the Haitian community. Clinics in this 
neighborhood tended to be very busy, had small offices, and patients sat in a stuffy waiting room 
on metal chairs. An interesting aspect of this clinic was that all the labels on the doors were in 
both English and Haitian Creole. I was invited to attend a health fair where I signed up clients 
for the different tests they would receive that day and gave people instructions on where to go. 
Although I took no official count I would say that the people seeking care were roughly 60% 
Haitian, and spoke only Haitian Creole. Attendees of the health fair were grateful to be receiving 
free services which included rapid HIV/AIDS tests, prostrate cancer screens, mammograms, and 
asthma monitoring.
I was recruited through CWHA to work as a promoter for Maimoneses Medical Center and Hospital’s upcoming health fair. During the fair I served as a walking advertisement for the upcoming Maimoneses health fair. I was asked to participate because I spoke both Creole and English and gave out promotional information and materials. Kreyòlfest is a concert that lasts several hours with high profile Haitian musicians. The energy at the concert was high. There were many people in attendance and a food vending area filled with Haitian food venders. I received permission to conduct interviews with Haitian subjects at the concert and finished 11 surveys.

A colleague at CWHA suggested that I visit the Caton Flatbush market which is nestled between clothing stores, restaurants, and shoe stores on Flatbush Avenue, a main street that runs throughout Brooklyn. The market is a welcome sight among all the urban clutter as it has a large empty area for produce sales at the front. This market is owned by the City of New York. The stalls cost $15.00 per day or $420.00 per month (NYC Business Solutions 2006). Informants reported that capital gains were roughly one hundred dollars per week. This market serves the West Indian, African, and African American community in this area of Brooklyn. At this market, there are ten Haitian-run stalls: rented by eight women, one man, and one to a married couple. Most stalls sell Caribbean country flag clothing, dried goods, spices and herbs, and Haitian food stuffs. There is one stall that sells Vodou flags, shakers, and herbal sexual remedies as well as art from Haiti and Ghana.

The Flatbush Haitian Center is located one floor below CWHA and offered social work services to families with drug addicted members. In contrast to CWHA the Flatbush Haitian Center was very quite as all client meetings occurred off-site. People here were very supportive
and welcoming. I attended a luncheon at a local elderly center with colleagues from the Flatbush Haitian Center.

I found the Linden medical clinic while walking from CWHA to the Caton Flatbush market. This medical clinic provides general medicine and provides services to people age fifty or older, although some younger people use this facility. The clinic staffed one doctor, one nurse, and an office assistant who were of Haitian descent and spoke Haitian Creole in the office. The staff introduced me as a researcher and asked people in the waiting room to participate. All subjects addressed agreed to an interview. The patients here were excited to talk as it seemed to be a good way to pass the time. They also asked me lots of questions and which made it easier for me to conduct the questionnaire. Often times when eliciting responses form one informant other people would chime in, sometimes they were related to the informant sometimes they were not. It was in these moments that interesting conversations began.

Dr. Marco Mason asked me to assist him in preparing a cultural training seminar for a group of midwives at SUNY Downstate Medical Center. I helped him in preparing all documentation and gave a short presentation on the social aspects of illness. There were 5 midwives in attendance and we all sat in a circle and were able to share are many experiences. We discussed issues of class, race, gender, and the impact poverty has on the health of people. This was a very successful seminar.

**Events and Participant Observation**

During my first week at CWHA I was sent to Health Advocacy Day along with 3 other female representatives from CWHA. Health Advocacy Day occurred at City Hall in Downtown Manhattan. Council members were appointed to hear all issues on the floor above the allotted discussion space for the advocacy conference. However, each time we rode the elevator to visit them and ask questions few were actually available. A 30 woman 2 man crew of advocates for
the different in-need communities in Brooklyn attended the conference. The conference consisted of each group speaking about different concerns in their community such as access to interpreters, the need for medication waivers for illegal immigrants, the need for funds for general health education and the incidences of the different health issues that plague their communities such as asthma, HIV/AIDS, low birth weight, and cancer. At the end of the formal presentations a press conference was held on the front steps. At first there were not many journalists, but lucky for our cause the Reverend Jesse Jackson and several members of the press appeared from within the building and spoke about the health discrepancies in Brooklyn. I was able to tape the entire speech while standing less then a foot from the Reverend.

I attended another health event sponsored by CWHA and Maimonides medical center and hospital about health disparities in the Central Brooklyn Community. I was appointed as note taker for this event called Community Strategies to Reduce Health Disparities: Connecting the Dots. The speakers were from local non-profits and several physicians from local hospitals who were concerned with the health care disparities that was occurring in the community. Race, economic position, migrant status, gender, and lack of funding for the poor were all main issues addressed.

**Data Collection**

The content for the medical questionnaire came from one month of observations, discussions, and attendance at health advocacy meetings in Brooklyn. The questionnaires administered to the health workers were written in English with limited Creole expressions that were translated or explained. Each included general questions concerning Haitian Patients, illnesses that occur in the community, Haitian folk illness knowledge, and socio-demographic information about each practitioner.
The content for the questionnaire with Haitian subjects was developed from observations made in the field as well as research from previous studies of Haitian folk illness (Murray 1976, Farmer 1988, and Coreil et al. 1996). These questionnaires included socio-demographic information, health-seeking choices, illness concepts, and knowledge of Haitian folk illnesses. Informants were asked about their sex, age, income level, and place of birth. Informants had difficulties with hypothetical questions so these types of questions were excluded. The content for the open-ended interviews was selected to address issues of stigma with Vodou-related illnesses, AIDS, and race.

**Summary**

Data from the survey were collected from ten Haitian subjects and twenty six healthcare workers and the information for the case studies was taken from four interviews. All interviews took place in public e.g., the Caton Flatbush market, CWHA, the Caribbean-American Center, Kreyòlfest, the Linden Medical Clinic, the Flatbush Haitian Center, and other private clinics and workshops.

<table>
<thead>
<tr>
<th>Location of Data Collected</th>
<th>Number of Questionnaires Conducted With Health Practitioners</th>
<th>Number of Questionnaires Conducted with Haitian Subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caribbean Women’s Health Association</td>
<td>7 (6 Women 1 Man)</td>
<td></td>
</tr>
<tr>
<td>Caribbean-American Center</td>
<td>6 (3 Women and 3 Men)</td>
<td></td>
</tr>
<tr>
<td>Caton Flatbush Market</td>
<td></td>
<td>5 (3 Women and 2 Men)</td>
</tr>
<tr>
<td>Flatbush Haitian Center</td>
<td>1 Woman</td>
<td></td>
</tr>
<tr>
<td>Linden Medical Clinic</td>
<td>6 (5 Women and 1 Man)</td>
<td>5 (4 Women and 1 Man)</td>
</tr>
<tr>
<td>SUNY Downstate Private Clinic</td>
<td>6 (6 Women)</td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>27</td>
<td>10</td>
</tr>
</tbody>
</table>
Figure 3-1. Map of field site locations [Created in google maps, www.google.com, 2005]
CHAPTER 4
SURVEY DATA

*Ti Moun se Richès Pòv Malèrè*
Children are the wealth of the poor

*Tout Maladi Se Pa Maladi Doktè*
All illness is not illness a doctor can treat

--Haitian proverbs

**Introduction**

The two proverbs above highlight Haitian beliefs and experiences in regards to theories of folk health. *Ti Moun se richès pòv malèrè*, addresses the importance of children to the Haitian people. *Tout maladi se pa maladi doktè* implies two things. First, that the Haitian medical system is medically plural and addresses a supernatural realm that causes sickness and cure. Second, people get sick and must live with it, take some herbs, and move on. This chapter presents results from data collected from ten surveys with Haitian subjects, and twenty-six surveys with health care workers that service the Haitian community. Illness concepts and categories are important to this research because the different responses people gave show the stigma inherent in some illness categories versus others. Twelve illness categories were addressed which ranged from AIDS to common cold to various folk illnesses. *Pèdisyon* (miscarriage) and *ti moun mare nan vant* (the tied baby) are two reproductive pathologies that form a continuum from biomedically understood issues such as miscarriage, to a folk illness—the tied baby. *Ti moun mare nan vant* is a way for women to explain infertility or temporary infertility issues in order to avoid stigma with in the Haitian community.

Health care workers in East Flatbush noted that diabetes and high blood pressure are common issues faced by Haitian patients. In regards to folk health issues health workers, in general, had not discussed these with patients and felt that patients believed in folk health
because they were uneducated. I found that women utilized folk illnesses as a way to protect themselves from the stigma associated with bareness and other reproductive health issues. However, while utilizing these indigenous theories of health women are faced with negative views from biomedical practitioners when discussing these problems.

**Illness Concepts Provided by Haitian Informants**

To investigate the range of illness concepts and categories utilized by Haitians in Brooklyn, the current research inquired about twelve illness categories. The categories were chosen for two reasons. First, some categories such as AIDS, cancer, and diabetes were both widely researched and addressed by the public health advocacy community in Brooklyn. Second, I wanted to have a range of illnesses so that the differentiation between biomedically based theories of illnesses, theories of non-illness, and folk theories of illnesses could be identified. Illness categories that help to frame biomedical theories of illness are AIDS, cancer, diabetes, cold/flu, mucus, and sprain. Menstrual cycle, pregnancy, and miscarriage helped to frame theories of non-illness while the tied baby, bad blood, and spoiled milk helped to frame theories of folk illness.

Table 4.1 demonstrates the ways that Haitian subjects consider illness. The illnesses listed range from HIV/AIDS, cancer, and diabetes to folk illnesses. Informants were asked to explain each selection and whether it was or was not an illness. These questions were asked of ten Haitian subjects. The Caribbean health advocacy and non-profit communities focus on testing and education concerning HIV/AIDS, cancer, and diabetes. Their focus on testing and education in these topics is because of research findings from the Department of Public Health. Central Brooklyn is labeled as below average, it is in the bottom ten neighborhoods out of 41 researched, in New York City for the following health issues: general health, maternal and child health,
infectious diseases, and chronic diseases such as diabetes (New York City Department of Health and Mental Hygiene 2008).

Death from AIDS and diabetes in central Brooklyn occurs two times more than for the rest of New York City while death from cancer occurs 25% more (2003 New York Department of Mental Health and Hygiene). In the East Flatbush and Flatbush neighborhoods of Central Brooklyn there is a 32% prevalence rate of HIV in the Caribbean foreign born population (New York City Department of Health and Mental Hygiene 2008). This is the highest percent of HIV of all United Hospital Fund (UHF)\(^1\) neighborhoods in Brooklyn. Therefore, it’s not uncommon to see free testing centers for HIV/AIDS, prostate cancer, and mammograms on the street or to be given condom kits with information about how to get a test for HIV/AIDS. AIDS, cancer, and diabetes analyzed together in this section because informants considered all three to be terminal diseases.

As seen in table 4.1, 90% of informants believe that AIDS (\textit{SIDA}) and cancer are diseases, and all informants believe that diabetes is a disease. AIDS was considered a disease by one informant because, “it transports to others” and another informant because “it is a virus and an epidemic.” One female informant said that cancer was a disease because, “it kills people and there is no treatment,” while another female informant said that AIDS and Cancer were diseases and that “people can be cured but the power structure stops them from getting what they need.” For both AIDS and cancer, several informants said they were diseases because “they affect your health” and because “they kill you.” Both AIDS and cancer were spoken of and described as

\(^1\) UHF is a nonprofit that funds research and philanthropy in New York City. They focus on having a positive impact on New Yorkers health. They work with hospitals, clinics, and other care centers and also work with civic leaders and others to impact change.
biomedically based and understood diseases. However, this has not always been the case in the Haitian understanding of AIDS.

When Farmer (1990) began studying AIDS in rural Haiti in the early eighties, it was considered a sickness of the city that dirtied weak blood, or that people with bad blood (move san) could more easily contract AIDS (Farmer 1990). However, by the late 1980s, these views changed and people in rural Haiti began to link AIDS to tuberculosis. AIDS was considered to be a sent sickness\(^2\) or to have been caught from a microbe\(^3\) (Farmer 1990). By this time there was also an understanding that AIDS could be caught through blood transfusions and sexual intercourse. Therefore, a strong belief in AIDS as a disease with informants is not surprising given the long history of both western biomedical and indigenous Haitian understandings of this disease. All informants believed that diabetes (maladi sik literally the sugar illness) was a disease, because it has grave affects on health and could kill you. The World Health Organization (WHO) lists that there are 161,000 documented cases of diabetes in Haiti out of a total population of 8,326,000 (.01\%) and a total public and private health expenditure of $INT 83.00\(^4\) in 2002 (WHO 2006). Haiti had the lowest health expenditure of any other area in the WHO region of the Americas. The total number of diabetes cases is much higher than the documented cases as it is clear that much of the population cannot afford, does not have access to, or chooses not to seek out, healthcare that offers such documentation. For comparison, the United States health expenditure was at $INT 5,274.00 in 2002 (WHO 2002).

\(^2\) Sent sickness is when one person sends an illness to another person by paying a oungan or bôkô to perform a ritual.

\(^3\) A microbe is a microscopic organism or germ.

\(^4\) This $83.00 is configured by the international dollars formula (INT). The international dollar accesses differences in the purchasing power of different currencies. International dollars are calculated using purchasing power parities (PPP), which account for differences in price level between countries (WHO).
In table 4.1 the next category of inquiry was cold or flu (grip) and mucus. Eighty percent believe that cold or flu is an illness. Sixty percent believe that the presence of mucus (larim) is an illness while two out of four informants thought both mucus and cold and flu are not illnesses, but they are ailments. Informants who thought cold, flu, and mucus are illnesses, thought that medication is required, but that these are not serious illnesses. Most informants, 60%, believe sprain to be an uncomfortable ailment because, “you must go to a doctor for medicine” and because “there is pain.” Two of four informants believed sprain to be accident, which, for them precluded its possibility of being an ailment or an illness, “it is an accident so it is not the same as being sick”.

Next, in the table the menstrual cycle, pregnancy, and miscarriage were considered to be non-illnesses and were grouped together because of this distinction. Ninety percent of informants did not think that menstrual cycle was an illness and all informants said that pregnancy is not an illness. Informants said that menstrual cycle was not an illness because, “you are supposed to get rid of blood each month, this is natural.” Informants also said that it caused people to have cramps or a headache, but that the menstrual cycle itself was not an illness, but caused women suffering. Informants said that pregnancy was natural. Sixty percent of informants did not consider miscarriage (pèdisyon) to be an illness. Informants said it was not an illness because, “it is an emergency” or that it was “an accident.”

Folk Illnesses

Afro-Caribbean folk medicine is based within an experiential framework. This means that it is based within a history of use by a group of people. Laguerre (1987:6) writes that, folk medical discoveries are analogs of conventional scientific experiments using repeated observations not *in vitro* but *in vivo*. Through experimentation, new techniques and new remedies which have been compared through trial and error are added to the *materia medica* of the people.
Folk medicine has a marginal status because of its relationship to biomedicine and is rejected knowledge by mainstream society because it is not strictly scientifically based. Although Laguerre does not focus on medical pluralism later writing on these topics addresses syncretism. Syncretism is relevant to this thesis because it shows that all societies have a mixture of medical systems and paradigms that they utilize even if some of the practices are taboo and carry stigma. Obermyrer states that syncretism occurs in Moroccan birthing practices. “Often in a home birth, the woman in labor will lie in a bed instead of squatting on the floor as is the traditional practice, and some traditional birth attendants give vitamin pills or injections or administer pain relievers in the form of suppositories in addition to using herbal remedies” (Makhlouf Obermyer 2000:190). In rural Haiti, Farmer (1988) found syncretism in the ways that people understand the etiology of an illness. Illness can be sent through magic, or can be the product of a microbe, germ, bacteria, or organism (Farmer 1990).

Are folk illnesses considered illnesses or diseases in the Haitian health cosmological viewpoint? This is a complex question because not all Haitian informants agreed as to whether a folk illness was a health problem at all, an ailment, an illness, or a serious illness. For instance, Paul Farmer notes that, “both pèdisyon and TMMV [Ti Moun Mare Nan Vant] seem to me [to be an] association with a large variety of pathologies and experiences-- from miscarriage (the most common) to infertility to dysmenorrhea to social problems around childbearing” (Personal Communication, Paul Farmer, 9/10/2008). This range of pathology and experience extend to all the folk illnesses discussed in this thesis.

**Pèdisyon and Ti Moun Mare nan Vant**

Although for the purposes of this thesis *pèdisyon* is being considered the word for miscarriage, this is not the case in all of the literature on this topic. Through my research I found that *pèdisyon* could mean a young “loose” woman or miscarriage. However, in the
anthropological literature, *pèdisyon* is the term used to describe what my informants called in my research as *ti moun mare nan vant* (the tied baby). When I asked Haitian subjects, “have you ever heard of *pèdisyon*”, they would say yes. When I asked them what it was, they always responded, miscarriage. At first this confounded me as the anthropological literature that I had read stated that the word for the child tied in the womb was *pèdisyon*. After this I began to describe the tied baby (what the literature called *pèdisyon*) to informants and then asked them for the name for it and they always said, “*ti moun mare nan vant*.” Murray (1991) writes that it is impossible for *pèdisyon* to be a miscarriage. Freeman’s (2004) Haitian –English dictionary states that *pèdisyon* is miscarriage (non-apparent), as well as an extended pregnancy (Freeman 2004). Thus, *pèdisyon* has several definitions in the literature or the definitions have changed over time. Murray (1976) translates it as perdition while Coreil et al. (1996) calls *pèdisyon* arrested fetal development syndrome. Murray (1976) translates *pèdisyon* from the French or English word perdition which is a state of spiritual ruin or utter damnation (Merriam Webster 2006). Singer, Davison, and Gerdes (1988) found that their informants described *pèdisyon* as a loss of blood (Singer, Davison, and Gerdes 1988).

In the structured interviews I asked four informants if *pèdisyon* and *ti moun mare nan vant* were the same thing in order to clear up my own confusion about the ways the two terms were being used differently. I found that all my informants considered *pèdisyon* to be a miscarriage and *ti moun mare nan vant* to be the tied baby. During the interviews, informants were asked to explain in more depth the difference between *ti moun mare nan vant* and *pèdisyon*. Out of the four people who responded, all of them said that *pèdisyon* and *ti moun mare nan vant* were different, but Nansi clarified the differences by saying, “they are the same in that they both affect your pregnancy, but they are different because a woman can deliver a child tied in the womb and
with a miscarriage she loses the baby”. Singer et al. believe that TMMV is a part of a folk illness complex that is “part of a larger complex of interrelated reproductive illnesses experienced by Haitian women” (1988: 375). This is a similar view to Murray (1976) and Coreil et al. (1996), who call TMMV a culture-bound illness that reflects a way of dealing with infertility or temporary infertility.

*Ti moun mare nan vant* (the tied baby), is a folk illness where, according to Murray (1976 and 1991) and reflected by some of my informants, occurs when the Haitian *lwa* (spirits) create this illness. With TMMV a woman is unable to give birth within the biomedically constructed notion of gestation. People believe that pregnancy can take up to five years when in this condition because the child is tied-up within the womb. Characterized by bleeding in the third month of pregnancy, TMMV becomes a problem because, in Haitian folk theories of health, menstrual blood is thought to nourish the fetus (Murray 1976; Singer et al. 1988; Coreil et al. 1996). If the menstrual blood resumes, the child is no longer being nourished and the fetus will shrink into a small spot that stays attached to the womb for several months or years (Murray 1976 and Singer et al. 1988).

The continuum of thought regarding the range of reproductive pathologies differed among informants. Of the five informants who believed TMMV was an illness caused by the *lwa*, two were not sure how, if at all, TMMV was related to pèdisyon while three informants thought it was related to pèdisyon in that TMMV and pèdisyon are both reproductive health issues which often have different outcomes, symptoms, and etiologies. Informants who did not think this was an illness (two) or did not know about it (three) did not give any insights about why they felt that way. TMMV is not the only folk illness that a range of pathology and experience can be applied to. All of the folk illnesses addressed in this research resemble each other in that people
attributed a range of pathology, belief, and experience when discussing them. *Move san* (bad blood), which occurs due to anger, shock, or grief related to interpersonal issues emphasizes this range.

*Move san* is a common illness in Haiti and the United States (Farmer 1988; Brodwin 1996; Wiedman 1978). Farmer (1988) found that 36 mothers (77%) of informants had experienced *move san*. Farmer (1988), believes that *move san* is “an illness caused by malignant emotions—anger born of interpersonal strife, shock, grief, chronic worry. It is thus not possible to relegate *move san* to such categories as ‘psychological’ or ‘somatic’ (Farmer 1988:63). Farmer (1988) argues that somatization is an over-simplification of the complexities at work in Haitian illness cosmology. These illnesses and their etiologies vary and include the realm of the supernatural. Farmer’s (1988) informants were reluctant to speak in detail about the exact incident or incidences that caused the anger, shock, or surprise. It is possible that magical poisoning could be a cause for anger, shock, or surprise that could cause *move san*. Farmer (1988) speculates that informants were reluctant to tell him details because of the possibility of magical etiology. Once the anger, shock, or surprise occurs, there are a series of possible symptoms.

Table 4.1 shows that *Move san* not only affects the blood, but it can affect the entire body including, "the head, limbs, eyes, skin, and uterus” (Farmer 1988:62). Symptoms of *move san* include anger, hives, sleepiness, lack of concentration, and back pain (Farmer 1988). The symptoms of *move san* that Farmer (1988) found were reflected in, and added to, in my research. Informants reported symptoms such as red eyes, scratchy voice, high blood pressure, diarrhea, crying, hives, stomachache, stroke, and death.

Six informants considered *move san* an illness. Three of these informants considered it to be a mild illness while three informants considered it to be a disease-causing illness. These
informants felt that *move san* was an illness because it impedes daily functioning, and could, in the worst cases, cause stroke, high blood pressure, or even death. The four people who did not consider *move san* to be an illness thought that it was temper, an accident\(^5\), or that it was not an illness itself, but that it could cause illnesses (such as stroke, high blood pressure, or death) to occur.

Farmer (1988) found that *move san* can be part of a complex that he calls the *move san/lét gate* (bad blood/spoiled milk) complex. Although Farmer (1988), and my research, found that both men and women could get *move san* women were more likely to have *move san* especially those who are pregnant or lactating (Farmer 1988). New mothers that develop *move san* almost always develop *lét gate*. Spoiled milk occurs when bad blood mixes with breast milk causing it to spoil. This can cause the nursing mother great harm and often results in the early weaning of a child (Murray and Alvarez 1981 and Farmer 1988). Although spoiled milk is affected by bad blood (Farmer 1988) my informants did not find consensus concerning the range of pathology for spoiled milk or its links to bad blood. One informant who believed bad blood to be an illness was unsure if spoiled milk was an illness or if it was just a symptom of bad blood while another informant who did not believe bad blood to be an illness was unsure if spoiled milk was an illness. The five informants that thought bad blood was an illness also considered spoiled milk to be an illness. Spoiled milk is considered to be an illness of the emotions which can cause serious mental problems or death if not treated with herbs or with allopathic medicine. Three informants who did not believe that bad blood was an illness considered it to be an “accident”. These informants thought spoiled milk to be a symptom of bad blood.

\(^5\) The use of the idea of an “accident” in relationship to health is complex and is something that I did not explore in this research. It could mean just a simple accident, or it could mean that another person hired a bókó (Vodou sorcerer) to place a curse on ones health (Freeman 1998).
Healthcare Workers

I was able to administer, in some cases in person and others through drop off, 26 questionnaires with several different types of health workers. These health workers were recruited from CWHA, the Caribbean American Center, the Flatbush Haitian Family Center, a health clinic on Linden Boulevard, SUNY Downstate, and a private clinic on Norstrand Avenue. The health workers at these sites ranged in position from social workers to community health workers to medical assistants, medical doctors, and several midwives. Creole and English were the top two languages spoken in the offices of health workers. Informants reported that twenty to 50% of their clients’ ethnicity was Haitian. Thirty eight percent of health workers were born in the United States followed by 27% who were born in Haiti. A good portion of the health workers were women (21) with five male respondents. Most health workers, twelve of the twenty-six, had a post graduate education with eleven of the health workers having some college or a Bachelors degree. Annual income for ten health workers was fifty thousand or over annually followed by nine informants who refused to answer this question.

The purpose of including health care workers in this study was to find their perspective concerning folk health issues in respect to their Haitian patients as this is important to understanding the experiences behind Haitians health and healthcare choices. Hypothesis one is supported by the data collected from healthcare workers. Hypothesis one states, that health care providers consider folk illnesses and the women who use these theories negatively. Healthcare workers in this study did not, in general, have patients discuss folk health issues with them. As well, they believed that patients who used theories of folk health were uneducated. In Haiti, Maternowska 2006, found Haitian doctors to have negative views and practices of their, usually poor, patients’ theories and practices concerning health and healthcare in Haiti.
Maternowska tells a story about Yvonne, a 24 year old mother of four, who was receiving birth control from a family planning center in Cité Soleil, Port Au Prince. Yvonne needed another pack of birth control pills, but because she had not gotten her period the doctor became angered with her and accused her of not taking her pills and coming too late to refresh her prescription. Yvonne defended herself by explaining to the doctor that he had given her 2 months worth of pills. He became enraged, threw her chart at her, and accused her of lying. Yvonne said nothing, but stood there until the doctor’s tirade was finished and left without her packet of birth control pills. Once the patient left the doctor continued by saying, “She’s so stupid that—she says she took two packets of pills, but she didn’t. Oh! It’s all the same! They’re still stupid, they still lie and they’re still slaves! (Maternowska 2006:77). When Maternowska checked the patients’ record the doctor had indeed prescribed her two packets of pills. Although the health workers in my study were not as vocal about their negative views toward their patients, Maternowskas’ analysis of these types of interactions situation is reflected in this Brooklyn in that the doctor-client relationship is a domain where ideology—doctrine of a distinctive perspective—is reproduced. The asymmetrical relationship, including the infallible doctor and the initially challenging client who, in the end has no choice but to agree with the accusations made against her, reflects and replicates the dominating structures that reverberate throughout Haitian society. In this way as Waitzkin contends, “Medical encounters become micropolitical situations that reflect and support broader social relations, including social class and political-economic power.” (1991:9 in Maternowska 2006:78)

**Biomedical and Folk Health as Reported by Health Workers**

When health workers were asked about common medical problems found in client’s high blood pressure and diabetes (88%) were the two most commonly found health issues followed by the common cold, asthma, HIV and Stroke (46%), and finally anemia, and eclampsia and etopic pregnancy. The percent of patients with diabetes or HIV/AIDS reflects the public advocacy
focus on diabetes and HIV/AIDS as main health concerns in Central Brooklyn. Although use of folk illnesses is a way for women to explain bareness and reproductive health issues there is a lack of understanding of this among healthcare workers, and thusly, on how the healthcare community can advocate for women experiencing these issues.

The questionnaire for health workers defined each of the three folk illnesses, bad blood, spoiled milk, and the tied baby, and asked them a series of questions concerning patient’s complaints in regards to these common problems. In regards to bad blood, eighteen health workers had never had a patient complain of this problem while seven health workers had patients who had complained of this problem. When health workers were asked if patients complained about spoiled milk eighteen of them said that patients never complained of this issue while seven health workers have had patients with spoiled milk. When health workers were asked if patients said they had a tied baby nineteen said they had never had this complaint while five health workers had dealt with this issue.

What does this mean? The low number of health workers who had not had patients complain about these folk concerns suggests that patients do not want to share this type of information with doctors for fear of chastisement or judgment. Although I was unable to follow patients into office visits this I believe—a doctrine of distinctive perspective—is at work because of two reasons. First, the health workers who encountered patients who complained of folk health issues were either midwives (two) or community health workers (five) and second, the health workers who had not encountered these issues had a common narrative about their patients. These health workers, eleven of them, reported that patients believed this way because they were uneducated and because of their poverty lacked access to proper health care. Although this is not the same chastising voice of the Haitian doctors Catherine Maternowska writes about
it is still a negative judgment concerning the social and economic standing of their patients, and thus, an example of the negative associations that health workers place upon Haitians who claim folk health illnesses.

In opposition to these negative attitudes were the positive statements made by health workers who had encountered clients with folk health issues. These women believed that it was important for medical doctors to respect client’s health beliefs in order to provide them with needed services in order to avoid women using unhealthy cures to solve folk health illnesses.

**Folk Illnesses and Stigma**

The importance of folk illnesses in Haiti and the United States is their larger relationship to stigma in the context of folk versus biomedical illnesses where Haitian folk illnesses are laden with negative associations concerning AIDS, *Vodou*, and Blackness. Haitian women who are struggling to come to terms with their lack of ability to bear children empower themselves and are able to cope emotionally and physically with bareness and reproductive health issues by using socially accepted folk illnesses in order to hold onto their sense of womanhood. However, once they, or if they, decide to use a folk illness to explain a set of symptoms to a doctor they are faced with negative attitudes because of their beliefs.

Women who claim *Move San*, *Lèt Gatè*, and *Ti Moun Mare Nan Vant* for different reasons, but all of these folk illnesses are ways to cope with stigma in relation to a lack of reproductive health. Bad Blood, spoiled milk, and the tied baby affect women of child bearing ages disproportionately to others in the population. This set of folk illnesses affect pregnant and nursing women (bad blood and spoiled milk) or affect women who have primary and secondary infertility issues (the tied baby). In Haiti, “social and economic pressure to mate after puberty...is high, as evidenced by the rates of fertility of young girls and women: by seventeen years, 19% of all woman already have a baby or are pregnant. The proportion increases to 31%
by the time Haitian girls are nineteen years old” (Emmus III 2000 in Maternowska 2006). The importance placed on fertility occurs because children pave the way for people to live a meaningful life. It is not only a rite of passage to adulthood, but children work, carry water, sell in the market, and cook food, just to name a few tasks. Also, with children is the possibility that the family will get out of Haiti through the child’s progress. Because of these reasons childlessness is considered a negative state of being (Leventhal 1987 in Maternowska 2006).

The persistence of the importance of child bearing continues in the United States for many of the same reasons except, now that they are out of Haiti it is for their children to become educated and create success for the family. For these reasons not being able to bear children is a “damaging social stigma among Haitians” (Maternowska 2006:90).

**Summary**

A range of illness concepts and categories, both biomedical and folk in origin, were addressed in this chapter to demonstrate what people believe and how they experience health. A background and description of how biomedical and folk illnesses are contextualized for this research is given and the data collected form the survey from Haitian informants is presented. The data collected from the surveys with health practitioners and an analysis of the links between folk illnesses and stigma highlight the main issues researched.
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CHAPTER 5
CASE EXAMPLES

_ Tout moun se moun_  
All people are people  
--Haitian Proverb

**Introduction**

_Tout moun se moun_, a popular Haitian proverb, reminds us that we are all the same at our core. This suggests that acceptance is an important aspect of Haitian philosophy especially since this proverb is used so often. However, the difficulty of maintaining this philosophy both within and outside of Haitian culture has been made apparent throughout this thesis and is clarified in this chapter through inter and intra group discrimination and through stigma women endure due to reproductive health issues and infertility. This chapter focuses on four case examples that reflect people’s range of experiences in regards to AIDS, _Vodou_, and Blackness and how these negative associations have been experienced by informants. All four narratives are connected to the larger themes of AIDS, _Vodou_, Blackness, and as well, either partially or fully support the hypotheses of this thesis.

The first two narratives are categorized under AIDS, Vodou, and Blackness because each narrative addresses how discrimination concerning one of more of these three themes is felt by informants. The first narrative, about Lifèt, concerns folk models to explain HIV/AIDS while the second narrative, about Nansi, concerns Vodou. The next two narratives are categorized under reflections on folk illness. In these narratives, folk illnesses, and how they are used and avoided, are made apparent through people’s experiences. In the first narrative, Lamèsi reflects on both traditional and biomedical health care experiences in Haiti and the United States. As well, Lamèsi’s narrative begins to address how infertility is stigmatizing through a story about
her daughter. Woz’s narrative includes opinions and stories about childlessness and illness from Woz and three other people who participated in the interview.

**AIDS, Vodou, and Blackness**

The following case examples share a common thread of experience in regards to AIDS, Vodou, and Blackness. These two narratives, through their different stories and life experiences, address how negative associations concerning these three themes affect their lives. In this first set of narratives Lifêt’s story highlights the relationships between discrimination, AIDS, Blackness, and the use of folk models. Nansi’s narrative highlights the relationship between discrimination, Vodou, and Blackness. The data from these two narratives fully support hypothesis two: the historical and social context of United States and Haitian relationships impacts folk health and biomedical health models concerning Haitians.

**LIFÊT: Folk Models to Explain HIV/AIDS**

A background of folk models as pertaining to AIDS is important to contextualizing Lifêt’s narrative because he uses folk models for explaining how people get AIDS. Some Haitians believe that the United States, with the support of the Duvalier government, used Haitian blood to test and create the AIDS virus. Luckner Cambronne, a Duvalierist, sold Haitian blood to the United States government earning him the name “Vampire of the Caribbean.” Some believe that from this blood the United States made the AIDS virus to target Haitians and stem migration (Farmer 2006). This may seem like an outrageous claim, but the United States has used AIDS to stem Haitian migration through the screening-in process¹. When the sale of Haitian blood became known in Haiti people felt that they had been wronged. Some Haitians believed that the

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¹ The screening in process is a term created by the Immigration and Naturalization Service to signify whether or not refugees have a credible fear of persecution if returned home when picked up during interdiction at sea. If they have credible fear they are required to be brought to the United States to apply for refugee status (Lennox 1993). However, in the case of Haitians, they were re-screened after first being screened in and tested for HIV/AIDS. Those with HIV/AIDS status were denied legal counsel and returned back to Haiti (Lennox 1993).
Duvaliers created *sida* (AIDS), while others believed that they sold-out to the United States and allowed Haitians to be used as test subjects for AIDS (Farmer 1990). Over time, Haitians believed that *Vodou* priests were being contracted by North American firms to build *sida*-teargas grenades filled with the virus that could be released to spread AIDS (Farmer 1990). These ideas about the origins of AIDS created a climate where Haitians felt that Americans blamed them for all grave illnesses (Farmer 1990). Real examples of this blame came from the CDC which throughout the 1980s and 1990s either labeled Haitians as AIDS vectors or as a group of people who could not give blood in the United States.

When AIDS discrimination began, Haitians in the diaspora looked to Haiti for their strength and power to help them in their newfound need for support. An example of this cross-border support surrounded the death of Ti Manno, a Haitian Compa musician. When people found out that Ti Manno was ill, money poured in from New York and all around Haiti to ensure that he receive the medical care he needed. Ti Manno is important to this discussion because his lyrics, especially from his 1985 record titled *Sida*, denounced oppression and discrimination—from the Duvaliers, the United States, or both. Glick Schiller and Fouron (1990: 329-330) write,

> Through his music, Ti Manno, more powerfully than any of the self-identified Haitian leaders, had attacked the stigmatization of Haitians as carriers of AIDS. This stigmatization was for him one aspect of the general rejection of Haitians by American society and the world, a rejection that he countered with assertions of Haitian pride and a strong positive Haitian identity.

During the 1980s and 1990s, at the height of AIDS discrimination, Haitians in the US were dealing with the double association of being Haitian and Black (Radhakrishnan 2003; Khan 1994; and Ong 1999). Drawing upon Appadurai’s (2003) idea of global cultural flow, for Haitians, this association with AIDS created a new reality within two nations—whether Haitian American, or newly arrived Haitians, to the Americans they were AIDS vectors. In Haiti, they
were received as United States citizens who gave economic, political, and social power to the Haitian nation-state.

Through blame, an element of stigma, Lifèt displays a typical response from the resulting feelings of stigma because of the social rejection and isolation that he felt when Haitians were designated as vectors for AIDS. This case model is important as Lifèt’s experiences in the United States address the themes AIDS and Blackness and his narrative fully supports hypothesis two of this thesis. In his narrative, Lifèt explains that race discrimination was the motivating factor for the United States medical communities’ designation of Haitians as AIDS vectors. Lifèt uses folk models and powerful metaphors to explain the spread of AIDS. He believes that condoms laced with AIDS are given to certain populations of people and blames the United States for the spread of AIDS as a device for ethnic cleansing. These folk models are based within, as hypothesis two states, the historical and social context of the United States and Haiti which has impacted the models Haitians apply to folk and biomedical health.

Lifèt was born in the south of Haiti in 1960. Currently he is a painter who owns his own gallery and is the singer for a popular rasin music group. He travels around the United States, including frequent trips to Miami, North Central Florida, and Chicago. When I asked him if he was born in the hospital he said, “My grandmother was the hospital.” In 1986, he came over to the US for political reasons.

In Port Au Prince we did a performance of the Bwa Kayiman\textsuperscript{2} ceremony to symbolize the need for us to break the chains of the government and to become free of years of oppression. This performance took place in Duvalierville. During the performance Macoutes with guns came and shot at us. We all ran and I kept running.

After this, Lifèt went back to the countryside and was in hiding for two weeks. His grandmother sent someone with the news that the Tonton Macoute had come to her house looking for him and

\textsuperscript{2} Literally, this means Alligator Woods. This was a historic Vodou ceremony that led to the Haitian Revolution.
that he should not return to the city. Later, his mother told him he had to leave Haiti and go to the United States.

In the late 1980’s, Lifèt was an organizer in Miami who gathered people to speak out against the United States designations of Haitians as AIDS carriers. During this time, Lifèt felt that there was some discrimination against Haitians although he himself never experienced this, but that, “they took us off the list of people with AIDS and everything is now fine.” Lifèt believes that the biggest discrimination that Haitians face is race discrimination. Lifèt believes that race discrimination was the motivation for the United States designation of Haitians as AIDS vectors. He, like Ti Manno, associates the United States with Babylon. Lifèt believes the United States wants to eliminate particular ethnic populations with the AIDS virus. Lifèt feels that he faces discrimination because he is Black everyday. “For instance if there is me, a dark-skinned Haitian, and a light-skinned Haitian who are up for the same job with the same qualifications, the light-skinned Haitian will get the job every time. In the United States, people discriminate because of skin color.” I asked Lifèt why he thought the United States labeled Haitians as AIDS carriers. He said that the reason for that is known by everyone, “the United States did this for political purposes they knew it was not true. They put this information out there like a bomb that spreads its poison over the people. AIDS is a weapon of mass destruction created to get rid of certain people like Africans or Haitians. The people in charge did this so that they could have control over certain people and keep themselves in power.” Lifèt believes that people in power created AIDS.

This is the same thing that they have done with condoms. Condoms can give you AIDS or other problems. They have two types of condoms some that they produce are normal and cause no harm and others have the AIDS virus in them. They do this so that there are more sick people so that they can make more money from selling medicine. AIDS is an industry.
Lifèt uses these folk models surrounding AIDS as a metaphor for how institutionalized power is plagued with discriminatory policies, which affect the ways people experience life. Lifèt has chosen to use his knowledge of these issues to protect future generation by creating a non-profit for children where he teaches them to embrace Haitian art, music, drumming, dance, and *Vodou*.

**NANSI: Vodou and Discrimination**

Similar to Lifèt, Nansi feels that she experiences race discrimination daily, but, as a *Vodou* practitioner must defend herself from both inter-group and intra-group stigma, but chooses to be empowered by her way of life. Schmidt sums-up stigma linked to *Vodou* by writing,

> The relationship between Haiti and the USA is a long and painful story. Haiti is a main target of US imperialism in the Caribbean, but Haitians are not well received within the USA. From the day it gained its independence in 1804, Haiti was portrayed as the land of black magic, cannibalism, and the like. (2003: 222)

When discussing with non-Haitian New Yorkers my work with Haitians, on several occasions I was warned about *Vodou* in the park. I was told by at least two different people (both non-Haitian) to stay away from the Haitians in the park. I was told that so-called black magic happened there and I could be harmed. Nansi’s narrative is relevant to this thesis because she addresses discrimination felt because she is both a Black Haitian and a *Vodou* practitioner. Her narrative addresses two of the three themes of this thesis. Nansi’s narrative is data for hypothesis two, but reflects the negative use of folk models differently then Lifèt’s experiences. For Nansi, instead of creating folk models to view others, others (usually Haitians according to Nansi, but also non-Haitians in my experiences as suggested above) have created negative folk models concerning her in relationship to her religious beliefs. People believe that she will cause harm, usually through poisoning or other illnesses, to them or their families. This way of thinking bout *Vodou* is based within beliefs created through, as hypothesis two states, the historical and social context of the United States and Haiti which has impacted the models Haitians apply to folk and
biomedical health. Nansi’s view of herself and her Vodou practice are in direct opposition to these folk models people hold concerning Vodou practitioners.

Nansi is a Vodou practitioner who serves the spirits in Prospect Park and looks to Vodou to prescribe how she lives life. She sells herbs, Haitian metal art, and Vodou ritual items in her booth at the Caton Flatbush market. Her hair, dress, and items in her booth all stand out and indicate that she is a Vodou practitioner who is involved with the Haitian rasin3 movement. To many Haitians and non-Haitians, she represents a threat. Nansi she experiences discrimination because she is Haitian, woman, and a Vodou practitioner.

Nansi feels that non-Haitians judge her because she is Haitian and a Vodou practitioner and Haitians judge her because she is a Vodou practitioner. Nansi, born in Port Au Prince Haiti in 1956 moved to the United States in 1980. Nansi attended high school in Haiti. In New York, Nansi worked in the non-profit sector with local youth and decided to begin selling in the market full-time because she believes that is her true calling. Nansi lives with her mother and one of her younger children. She lives within walking distance of the market she works at and enjoys her life of travel and caring for herself and her family.

Nansi is a known Vodou practitioner. This can be seen in the African-styled clothing she wears, the dreadlocks in her hair, and the items for sale in her booth at the market. When Nansi first came to the market there were many problems. All of the other women and men who sell at the market are protestant and they held a grudge against Nansi because she, as far as they were concerned, served evil. The Haitian women in the market shunned her and treated her poorly. People felt this way toward Nansi because of the common fear that a Vodou practitioner would

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3 The Haitian rasin (roots) movement is a musical corollary to a socio-political grassroots movement for structural change in Haiti, which does use revitalization and interpretation in their practices and interactions with Vodou. Roots people attend Vodou ceremonies in the countryside and draw upon like-minded movements and music such as Rastafarianism and reggae.
become angry or jealous and send a sickness, death, or other health related misfortune to them. By not associating with her they could avoid these calamities. After time passed peoples’ attitudes changed, “they saw me bring many intelligent people to the market whether they were White, Black, or Asian. These people purchased from me and this began to change their minds about who I was and what I represented.” Although people came to respect Nansi for her skills as a sales woman they still create political difficulties for her at the market because of her religious beliefs.

While I was visiting Nansi one day, a local Vodou priest, Brickner, who manages the lakou⁴ that Nansi belongs to, stopped by. We began to talk about Vodou. He explained that Vodou was a balance of good and bad, negative and positive things must happen in the world to keep that balance intact, including people’s health. I asked Brickner about sent sicknesses and TMMV. Brickner explained that sent sickness is a part of the balance of positive and negative that occurs in the world. Sent sickness is considered to be a negative aspect of the role of Vodou in people’s health. This causes negative health. However, he explained, there are positive things that can be done for protection or healing that is a part of the necessary balance to life and healing. Brickner said that knowing when to send a sickness “is about wisdom and how to use the knowledge you have about Vodou and when to use it for positive or negative.”

Nansi agreed with him and explained the role of Vodou in her life in more depth. “Vodou is not bad. It represents the earth, the sky, the water. The food we eat and the trees around us are all a part of Vodou. Vodou is in the way you live and the way you eat, dress, and function

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⁴ In Haiti A lakou or courtyard is the family compound that connects several Haitian houses together. In the US lakou has become a metaphor for a Vodou priest and his practitioners who practice in the same Vodou family. Lakou here represents the familial ties through religion this group has without the physical connection to a courtyard or genetic connection of the family.
everyday. *Vodou* is all about love...one love”\(^5\). As far as the discrimination she faces because she is a *Vodou* practitioner, she says it mainly has to do with ignorance.

People do not like that I serve the *lwa*—especially some Haitians. They feel negatively because people in their families may have had a bad experience with *Vodou* and now they think it is bad. Or the people in their families have not had a bad experience and they still say it is bad. People are ignorant they do not know what they say and they do not give good people a chance.

Because of her way of life, Nansi feels that she experiences discrimination on a daily basis.

Nansi said, “Every single day I experience discrimination because I am a Haitian woman and because I am linked to *Vodou*. People come to the market that I work in and sometimes they know I am Haitian right away because of the things I sell and the way I dress.” Often these people will not make purchases from me. Nansi said in one conversation, “discrimination occurs to people because of the ignorance that other people have against them. For you, perhaps this happens because you are a woman, for me this happens because I am black and Haitian and a woman.”

**Reflections on Folk Illnesses**

This set of case examples’ share a common thread of experiences that, first, people do not go to, or should not speak to, medical doctor’s concerning folk illnesses, and second, felt stigma in regards to TMMV. Women must defend themselves to other Haitians when dealing with bareness and reproductive health issues by using folk theories of health to reinvent these illnesses as temporary health concerns, rather then a permanent inability to produce children. As well, if women choose to divulge this information to health care practitioners they face a negative response i.e. the judgment that they are uneducated, or worse, and so choose to not include health care professionals when dealing with these issues. Lamèsi’s case example fully supports

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\(^5\) One Love is a common reference given by young *Vodou* practitioners in reference to Bob Marley who has touched the hearts and minds of so many globally.
hypothesis three—women with reproductive health issues use folk models to explain bareness due to the stigma associated with infertility. Woz’s narrative partially supports hypothesis three as Woz herself does not use folk models to explain infertility, but Anayiz knows people who use folk models in regards to infertility.

**LAMÉSI: Using both Haitian and US Biomedical Health Systems**

Lamèsi reflects on folk illnesses and how she experienced them in both Haiti and the United States. I interacted with Lamèsi 5 days a week for 3 months. Throughout this time we conducted a survey and two interviews where, gradually, Lamèsi became comfortable with me and began to share her experiences with folk illnesses. Lamèsi’s narrative is relevant to this thesis because her stories of herself and her daughter reflect both the three themes of AIDS, *Vodou*, and Blackness, and the third hypothesis, that women with reproductive health issues use folk models to explain bareness because of the stigma associated with infertility. Lamèsi’s stories are indicative of the ways in which Haitian identity and related health concepts are negatively associated with AIDS, *Vodou*, and Blackness. Lamèsi associates certain Haitian health issues and folk models with *Vodou*, a practice she considers to be unacceptable. She has internalized the three negative associations of AIDS, *Vodou*, and Blackness and tries to distance associations with *Vodou* through a religious conversion from *Vodou* to Christianity. Due to this conversion Lamèsi and her family must find other ways of dealing with infertility issues when addressing the Haitian community. Lamèsi tells a story of her daughter’s issues with infertility, but clearly states that she is careful when discussing her, and her family’s use of folk health remedies or beliefs. Lamèsi feels that these ideas are linked to *Vodou* and, therefore, she would be linked to *Vodou*. For Lamèsi this is unacceptable because she depends upon the support of her church community and an affiliation with *Vodou* may risk the loss of this support network.
Lamèsi was born in Haiti in 1940. Born to a madanm sara (international wholesaler), Lamèsi was only able to attend school through the first grade. In New York, similar to her mother, Lamèsi sells goods at the Caton Flatbush market where she earns $500 each month. She migrated to the United States in 1991 because of political conflict in Haiti. Currently she lives by herself as her son (one of her three children who reside in the United States) recently moved away, but a friend comes to stay with her at night in her apartment. Lamèsi, a Protestant, attends a Haitian Fundamental Christian church.

With the birth of her first child in Haiti, Lamèsi experienced both move san and lét gaté. Although she had delivered her child in a hospital she went to the leaf doctor to help her with these folk illnesses because, as she stated several times throughout the interview, “doctors do not want to help us with these types of issues”. It seems, much like the experiences of Maternowska’s clients in Haiti, Lamèsi knew she would be taunted by a medical doctor if she divulged her folk theoretical concerns. She was able to cure move san and lét gaté by drinking herbal teas and orange juice and bathing in herbs to cleanse her body and spirit as directed by her leaf doctor (dokté féy) and with knowledge about herbs that her mother had passed down to her through oral tradition. A few years later Lamèsi experienced an ekspedisyon (sent sickness). As is common with ekspedisyon she was sent a sickness by a jealous lover of her new husband.

I was married to a man who had a mistress. That woman was angry with me for getting married to him and soon after I became very ill. The woman admitted to causing this sickness and my husband had nothing to do with her anymore. I became a protestant to serve God and pray to him [God] and took some herbs and I never got sick like that again. God helped me. The woman used a Vodou priest to send this sickness to me. Because of this I repented to make my life better. I have accepted Jesus and no one can harm me.

Lamèsi avoided biomedical practitioners when trying to cure folk health issues because of the negative attitudes concerning folk health in the biomedical realm. When Lamèsi and her family migrated to the United States they did not abandon their ways of addressing folk health issues.
They still used the folk medical system for folk illnesses and teas for prevention of allopathic
diseases, but now, had increased access to healthcare with a biomedical doctor. After her
religious conversion and migration to the United States, Lamèsi expressed that she was not
comfortable sharing her or her family’s use of herbal remedies with other Haitians (only her
immediate friends or family) or her doctors. She became especially guarded when telling a story
about TMMV because she wanted her daughter to be able to get married. However, in the
second interview, she finally discussed her daughter’s encounter with TMMV. She said, “My
child thought she was pregnant, there was no menstrual cycle, but she was never able to give
birth. In Haiti they would give her a massage and a bottle of medicine to make the baby strong.”
When I asked her how they helped her daughter she would only say that she did not go to a
doctor because doctors could not help her daughter.

An interesting aspect of her need to keep this bought with TMMV quiet was a connection
she made with good fortune that came through her church. She confided she was glad they had
kept her daughter’s issues with TMMV private because recently her son applied for, and
received with the help of their church, a state-paid position in Chicago. It seems that Lamèsi was
worried that her daughter’s bareness could affect the church’s decision to help out her family
members.

**WOZ: Childlessness and Illness**

Woz owns a restaurant and, at the time of the interview, there were several other people in
the restaurant, and is Haitian custom, everyone became involved in our conversation. The folks
involved were Anayiz, Woz’s assistant, and Frank and Pyé two of Woz’s customers. This
narrative is relevant as several different stories are told in regards to childlessness and folk
illnesses. In Woz’s case, she, contrary to hypothesis three, does not use folk theories to explain
her childlessness. When asked about TMMV and miscarriage she claims to have never heard of
these types of issues. As she is clearly uncomfortable with these topics she invites her assistant and restaurant patrons to partake in the interview. Anayiz’s story of TMMV fully supports hypothesis three in that her narrative suggests that if women use folk health theories to explain bareness and other reproductive health issues they can find a cure for infertility.

Woz’s restaurant is in East Flatbush where she boasts a dedicated, but small, clientele that she has built up over the past four years. The restaurant has about four tables and boasts a successful take-out business. Woz went to cooking school in New York City and lives with several family members whom she supports. She works at her restaurant seven days a week for twelve to fourteen hours each day. Woz was friendly when she heard I wanted to interview her and in exchange I would work at the restaurant that day. I worked at the restaurant serving patrons and cleaning up for several hours. After we had prepared all the meals for the evening rush we sat down to begin the interview process.

Woz who is a childless and unmarried woman of forty-three is singular to my research in this respect. Every other woman I interviewed had children and, at some point in their lives, had been married. In fact, at one point when talking with some women in the market the importance of bearing children was made clear to me. They asked me if I had any children. When I responded, “no”, they asked me why I hated children so much. When Woz said that she did not have any children she became uncomfortable and I did not ask anymore questions regarding these topics after reflecting on my own experience with my admitted childlessness. Not surprisingly, when I asked Woz about TMMV and pèdisyon she claimed ignorance and turned to Anayiz and her clientele and asked them if they had ever heard of such a thing. Woz was unable to bare children and this is why she became flustered when I asked her about TMMV and pèdisyon.
At this point, as is usual when people have disagreement concerning a topic, the conversation became quite lively. Several people were often talking at once and, on occasion, talking over one another. Sounds of exasperation and head-shaking (back and forth signaling “no”) ensued along with other forms of body language that expressed disagreement and frustration. Everyone else in the restaurant had heard of one, or both, of these issues. The first customer, Frank, said that he had heard of *pèdisyon* and TMMV. He said that they were two different problems that women faced. *Pèdisyon* said Frank “is when you lose a child. You must go to the hospital and have doctors or nurses help you with this. With TMMV a woman does not have blood nourishing the child and the baby does not develop.” He continued to say that in order to make your blood strong and save the baby people may drink the blood of a tortoise mixed with bull’s heart. When Frank said this Woz became flustered and upset. When I asked her if she disagreed she said that these types of behaviors were disgusting and that she doubted people behaved like that. Anayiz, Woz’s assistant agreed with Frank and began to tell her personal experiences with each of these problems.

Anayiz described a miscarriage she had experienced in depth. When asked about TMMV she said, “TMMV is another problem all together”. Anayiz herself has never had TMMV, but a friend of hers has had this problem so she began to describe it.

If you go to the doctor, they cannot help you because they will say they cannot cure this type of problem. If you go to where they will give you herbs, your child will be healed and will become good and strong. TMMV is not easy for people to deal with because people want as many children as possible. You can also go to the *bòkò* who can tie or untie a child. The *bòkò* can cause miscarriage too. After the *bòkò* unites the baby for you it can still take longer, like 10 or 11 months for you to have a baby and sometimes even longer.

When Anayiz had finished speaking, Woz, and the second male customer, Pyè, disagreed with her. They became upset and said that what she has said is not possible. Pyè speaks up loudly and begins to disagree. He makes noises in disagreement and tells Anayiz that she is wrong and
that she is speaking nonsense. Woz and Pyè felt that TMMV, and the herbal ability to cure it was impossible. Pyè told me that TMMV was not real that women used this as an excuse to keep their husbands.

Summary

In summary, these four narratives support hypotheses two and three, and, are examples of how the main themes of AIDS, Vodou, and Blackness are negative associations that affect Haitian identity. Lifèt and Nansi’s narrative fully support hypothesis two while Lamesi’s narrative fully supports hypothesis three. Woz’s narrative, because it includes more than one person partially supports hypothesis three because Woz does not use folk models for infertility although Anayiz does use folk illnesses to situate infertility.
CHAPTER 6
CONCLUSION

Introduction

In this chapter, the findings are related to the research hypothesis. Also discussed are the various theories that address the topic. Examples of narratives are given to show how the data and hypothesis are linked to folk models and the ways in which folk models impact peoples everyday lived experiences with health and healthcare. These experiences show how Haitians and their healthcare workers create, interpret, and internalize what is considered normal and abnormal in society.

Haitian identity and related health concepts are negatively associated with AIDS, Vodou, and Blackness by both Haitian and United States formal medical institutions. Experiences of health and healthcare of the Haitian community in Brooklyn reflect these negative associations. This study found that folk theories of health, in particular, move san (bad blood), lèt gatè (spoiled milk), and ti moun mare nan vant (the tied baby), and folk models for the spread of AIDS are associated with stigma.

The hypotheses concern the following:

1. The historical and social context of United States and Haitian relationships impacts folk health and biomedical health models concerning Haitians.

2. Health care providers consider folk illnesses and the women who use these theories negatively.

3. Women with reproductive health issues use folk models to explain bareness due to the stigma associated with infertility.

Findings

Hypothesis one is supported through the historical background and context of US and Haitian relations. Considering the first hypothesis, informants’ experiences highlight issues of discrimination in relationship to AIDS and Blackness and Vodou and Blackness respectively and
how they interact with folk models of health. The narratives of Lifèt and Nansi, for example 
show how race discrimination and religious discrimination affect individuals. Lifèt feels that 
race discrimination was the driving force behind the CDC’s designation of Haitians as AIDS 
ectors and. Lifèt uses folk models and powerful metaphors to explain the spread of AIDS. He 
believes that condoms laced with AIDS are given to certain populations of people and blames the 
United States for the spread of AIDS as a device for ethnic cleansing. Nansi’s narrative is a 
reflection of the ways that the historical and social context of the United States and Haitian 
relationships impact folk health models because of the ways that other people construct Vodou. 
Nansi’s status as Vodou practitioner opened her up for both Haitian’s and non-Haitians to 
develop folk based ideas concerning whether or not she can cause illness and destruction in their 
lives.

Hypothesis two is supported as healthcare workers do consider theories of folk health and 
the woman who use them negatively. In the data here, most healthcare workers did not have a 
patient discuss folk illnesses with them and stated that women who used folk theories for health 
were uneducated.

Concerning hypothesis three, women with reproductive health issues use folk models to 
explain bareness due to the stigma associated with infertility, is supported. Lamèsi’s and Woz’s 
narratives are examples of women avoiding stigma when defending themselves to other Haitians 
concerning bareness and reproductive health issues. They use folk theories of health that 
reinvent these illnesses as temporary health concerns. In Lamèsi’s narrative, even though she 
and her family risk losing the support of their church, they continue to use folk theories of health. 
However, they are careful when discussing folk theories with people outside of their family.
Woz does not use theories of folk health to describe her childlessness, but, Anayiz, her assistant, tells a story that affirms the use of *ti moun mare nan vant* to explain infertility.

**Making the Connections: The Findings Relationship to the Literature**

The data collected support the hypotheses that relate to the literature on transnationalism, stigma, and ideas of normal and abnormal, by the use of folk and biomedical systems of health. Transnationalism is reflected in the ways in which Haitians in the United States construct their social interactions and form identity because they participate in two nation-states. This means that Haitian migrants must integrate nationalist social categories from both nations into their construction of identity. Negative associations by the current country of residence identify Haitians with AIDS, *Vodou*, and Blackness. These are a part of these nationalist constructions of self. For example, both Nansi and Lifèt’s narratives exemplify how this interstitial space becomes an arena of resisting practices. By empowering herself through exertion of her Blackness and participation in *Vodou*, Nansi is resisting the predominating negative associations of being Haitian and a *Vodou* practitioner. Lifèt shows resistance by educating himself and others about discrimination, and the uses of folk models as a resisting practice.

Issues of racism affect the ways in which Haitians experience health and healthcare in the United States because of the history of Black bodies being linked to disease and, specifically for Haitians, Haitian bodies being linked to AIDS. Lifèt’s narrative about the political motivations of the CDC’s choice to label Haitians as “vectors for AIDS” is an example of how Haitians experience this type of discrimination. Lifèt feels the impact of the social rejection and isolation associated with the stigma of being designated as a carrier of stigmatized disease.

Social rejection, isolation, and the stigma based on disease is also a part of the ways in which difference in regards to what is “normal” or “abnormal” is constructed. Ruth Benedict (1934), and Irving Goffman (1963), considered these themes of how ideas of normality and
abnormality affected people’s lives. Goffman elaborated upon the ways in which individuals and
groups internalized, and reacted to, attributes of difference. For Haitians, their use and
application of folk health theories is whether to avoid or react to stigma. For example, the
distinction between normal and abnormal theories of health was manifested by healthcare
workers in Brooklyn who reported that patients did not discuss folk health issues with them and
that if people subscribed to folk theories of health, it was because they were uneducated. By
ascribing an abnormal status to folk illnesses patients who utilize folk theories become
stigmatized. However, Haitian women continue to claim folk illnesses such as TMMV because
there is a chance that a woman can cure it, and conceive a baby, while they say bareness cannot
be cured.

Lamèsi and Woz’s narrative show how Haitian women use multiple systems of healthcare
in Haiti and the United States. Laguerre discusses the ways in which Afro-Caribbean
populations use the healthcare systems available to them. In the case of Lamèsi, and from what
Anayiz (from Woz’s narrative) expressed concerning folk illnesses, they followed one aspect of
Laguerre’s (1987), model—they used folk remedies for minor issues or as a preventative and
used biomedicine for major health issues. To add to this, both women suggested that when
dealing with TMMV, it was necessary to seek folk health practitioners because biomedical
practitioners would not, and could not, cure bareness.

**Future Research**

Negative associations of Haitians with AIDS, *Vodou*, and are experienced in daily life. In
the United States qualitative and quantitative studies on stigma and the different ways that it
affects people’s lives could delve further into how AIDS, *Vodou*, and Blackness impact Haitians
consciousness in regard to stigma. My questions surrounding stigma show some of the ways that
stigma is internalized. An in-depth study could be designed and implemented using participant
observation, cross cultural comparison, interviews, survey, and free list and pile sorts to show how the extent of each of these factors (AIDS, Vodou, and Blackness) are related to each other in the consciousness of Haitian people. A larger sample size than used here would be required as well as multi-site ethnography in the United States and Haiti for a more complete study.

**Conclusion**

This chapter discussed how folk models in relationship to health and healthcare choices are complex interactions that include identity. Stigma based on constructions of AIDS, Vodou, and Blackness form a part of the folk models themselves. The research findings provide evidence that support the hypotheses. Access to healthcare that incorporates local ideas of health and healing surrounded by a discourse of acceptance would help to de-politicize the healthcare system that could help to alleviate stigmatized cultural experiences.
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BIOGRAPHICAL SKETCH

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