Pèdisyon and Indispozisyon:
Reproductive Illness and Embodied Experience in Haiti

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Abstract: This thesis explores anthropological documentation of reproductive illnesses in Haiti and how these illnesses shape maternal and infant health outcomes. Through examining gender roles, health infrastructure, and medical beliefs in Haiti, I provide context for a framework that posits these illnesses as embodied history, trauma, and experience. Furthermore, I examine the evolving intersection of Vodou and biomedicine and its role in informing reproductive illness discourse and treatment. Finally, I propose ways in which an understanding of these illnesses can be integrated into health services in order to improve maternal and child health in Haiti.
TABLE OF CONTENTS

Abstract .................................................................................................................................................. 3
Acknowledgments .................................................................................................................................... 5

Introduction ............................................................................................................................................... 6

Chapter One
Anthropological Documentation of Reproductive Illnesses in Haiti ............................................. 12

Chapter Two
Poto Mitan and the “Axis of Gender” ................................................................................................. 35

Chapter Three
Bad Blood and Blood Pressure: Medical Pluralism in Haiti ......................................................... 49

Chapter Four
Making Meaning of and Treating Reproductive Illness ................................................................. 60

Bibliography ............................................................................................................................................. 67
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Finally, I dedicate this to the men and women whom I interviewed, who touched my life with their narratives of loss and hope, and to the friends I have made in Haiti over the last three years.
Introduction
Tracing the Roots of Trauma from a Hillside in Fondwa

View from a mountaintop in Fondwa, Southern Haiti. October, 2010
Although this paper engages with an anthropological study of women’s reproductive health terminology in Haiti, it was inspired by personal experiences in Haiti. Between October 2010 and May 2012, I had the opportunity to travel to Haiti three times with the Duke University Haiti Lab and conduct global health fieldwork. While this paper does not incorporate data from these interviews, my fieldwork exposed me to people, places, and discussions that were vital in sparking my curiosity about reproductive illness in Haiti.

I will never forget the first woman’s narrative I listened to in Haiti. It was approximately seven months after the January 2010 earthquake that devastated much of the Southern half of the country, and I had travelled to the rural community of Fondwa with several Duke professors, students, and doctors to conduct interviews with earthquake survivors. Fondwa is nestled in the breathtakingly beautiful – but largely deforested-– mountains of Southern Haiti. It is accessible from a major national route by a steep, winding paved road that leads down to the town “center”- a small cluster of buildings including a convent, a school, and an orphanage. After descending the hill and settling into our guesthouse adjacent to the convent, we set off to begin interviews. We walked along a dirt path, climbing up and down grassy hills until we reached a clearing with a small, wooden house. There we met Jezila, a woman in her thirties who welcomed us warmly into her home and procured chairs for all of her guests.

I immediately noticed the fatigue in Jezila’s eyes, but it was not until she began unraveling her story that I realized the extent of the burden she carried. Her father lost his leg after it was pinned under a building during the earthquake. He now requires constant care. Her husband, a construction worker, was working in the local school at the time of the catastrophe; he was one of only three men in his crew to survive the building’s collapse but suffered serious injuries that limited his
mobility and cognitive function. In addition to taking care of both her husband and father, Jezila also had five children to look after. She expressed hopelessness in her future and noted that she was frequently anxious and overwhelmed by her various responsibilities. Furthermore, she described herself as an “esklav” or slave, a term that is steeped in grave historical significance in Haiti given its status as a former French colony, where slavery was more developed as a system of capital than anywhere else in the Western hemisphere (Dubois, 2012).

Jezila’s reality was my first glimpse of the extreme hardships brought on by a convergence of adverse events and inequalities. From birth, Jezila’s gender weighted her with future expectations of caretaking, for both children and elderly relatives. The lack of health care infrastructure, social services, and economic opportunities in Haiti burden women like Jezila in their daily struggles. Finally, the catastrophic death and destruction Jezila witnessed on January 12, 2010 exacerbated her already difficult reality. Not only was she now faced with mentally processing the horrific events she’d experienced, she also assumed the role of assisting her relatives with their coping each and every day. The trauma that resulted from the earthquake in Haiti was thus two-fold: it encompassed both trauma from the physical disaster and trauma from the prolonged life changes that occurred as a result of the disaster.

I was fortunate to travel to Haiti twice more after this initial visit and hear many more narratives of loss and coping during and after the earthquake. Through conducting qualitative interviews in tent cities, we learned about the various ways Haitian men and women describe trauma and attempt to mitigate its effects, from
calling on God to seeking herbal remedies from a local doktè fèy, or leaf doctor.

Although the content of these interviews is not the focus of this thesis, the responses we recorded inspired me to explore the intersection of trauma and illness in Haiti. When we asked tent camp residents how they felt a year after the earthquake, most did not respond in the discourse of mind/body dichotomy that defines biomedicine. A common response was “Kò m kraze,” or “my body is broken/weak.” A majority of respondents identified that it was normal to become physically ill after a traumatic event such as the earthquake, and that this illness often included headaches, fever, trouble sleeping, or a general sense of not being well (pa byen). In Haiti, trauma is embodied, resulting in perceived weakening of the whole body.

It was also through these two subsequent visits that I became interested in women’s health in Haiti. During the summer of 2011, I lived in Léogâne, a city of around 100,000 people located twenty miles west of Port-au-Prince, with seven other Duke students. We conducted surveys for the research department of the Durham-based nonprofit Family Health Ministries, which focuses on a number of women’s and children’s health projects: cervical cancer screening, traditional birth attendant training, and children’s nutrition, to name a few. While four of us conducted research on trauma, the other four students in our group conducted maternal morality surveys, interviewing female friends and relatives of women who passed away during childbirth to determine cause of death. Through engaging closely with women’s health issues during the summer, I gained an appreciation for the magnitude of maternal health problems in Haiti, from the high rate of eclampsia
(14 per 2,000 pregnancies in Haiti, or 14 times the rate in the U.S.) to the lack of access to obstetric care in rural areas of the country (Associated Press, 2009).

My primary and secondary research explores the intersection of these two areas: How do social factors, trauma and maternal health interact in Haiti? The complex ways in which traumatic life experience shapes women’s health are most evident in a number of stress-induced ailments that disproportionately affect pregnant women in Haiti. These multiple maladies range from “bad blood” brought on by interpersonal conflict to debilitating shock caused by a particularly traumatic birth experience. My goal is to trace multiple forces that shape the onset, course, and treatment of these illnesses. In particular, gender inequality, Vodou conceptions of mind and body, and realities of traditional and biomedical health infrastructure in Haiti all contribute to the embodiment of trauma among pregnant women and new mothers. Finally, what are the public health implications of these health conditions? What are the long-term effects of this embodied experience on maternal and child health? Who should treat these women, and how? Ultimately, it is imperative that women’s health initiatives in Haiti understand these ailments and consider the multiple related interactions they represent - between gender and health, between psychological and physical health, and between traditional medicine and biomedicine – in order to improve health outcomes for women like Jezila. Although Jezila did not personally cite any of these specific reproductive illnesses, her story forced me to think critically about the risks and vulnerabilities of women who bear children in Haiti and the way in which the burdens of everyday life leave their mark on the body.
Chapter One

Anthropological Documentation of Reproductive Illnesses in Haiti

Figure 1. A map showing sites of reproductive illness documentation, 1906-2011.
On my most recent trip to Haiti, three professors, three students, and I stayed in the city of Léogâne for five days in May 2012. Our goal for this week was to supplement our existing trauma interviews and introduce several new questions. After one day interviewing in tent cities, psychologist Dr. Karen O’Donnell led efforts to develop a second questionnaire to add to the process. This one, which she called Standard of Care, asked questions about existing health and social support resources in the community of Léogâne; essentially, we wanted to know where residents felt they could turn in a time of poor physical or emotional health. Some of the questions were associated with specific ailments- i.e. “What would you do if you
or a family member were facing severe depression?” while others were related to adverse events - losing a loved one or losing a job, for example.

It was during one of these interviews that I first personally encountered a mention of reproductive illness in Haiti. During an interview with a middle-aged woman, we asked what treatment options she would pursue if she or someone she knew were scared or panicked often (gen kè kase oswa panike souvan). She responded that one must consult an herbal healer, or doktè fèy. This, she continued, was the best way to treat the problems of bad “san,” or blood, and “lèt,” or breast milk, triggered by these emotions. Move san, or perceived bad blood arising from emotional turmoil, has been documented as a culture-bound syndrome in anthropological texts for decades. In our interview, as in past studies, it was a clearly defined problem with modern relevance linked to a specific etiology (fear or panic) and treatment (herbal medicine).

Anthropological narratives have examined reproductive illness in Haiti primarily through collecting “ethnographies of illness,” or descriptive accounts of people who perceive themselves to be ill (Singer, 1988). To borrow from Merrill Singer, Lani Davison, and Gina Gerdes in their research on “Culture, Critical Theory, and Reproductive Illness Behavior in Haiti,” the discrete category of Haitian women’s reproductive illness can be defined as “indigenously named complaints and conditions that are localized in reproductive organs or associated with reproductive functions” (Singer, 1988). A number of these conditions have appeared in literature over the years; however, these texts primarily examine specific illnesses rather than acknowledging and connecting the range of afflictions that
exist under this umbrella category. In this chapter, I seek to synthesize a range of “ethnographies of illness,” qualitative research projects, and epidemiological texts to compare four reproductive illnesses in Haiti: move san/lèt gate, pa pale, pèdisyon, and matris deplase. Before I examine the ways in which these illnesses are embedded in the context of female realities and medical systems in Haiti, it is helpful to outline their symptoms, treatments, and personal narratives.

A. Move san and lèt gate

A strikingly early mention of the Haitian disorder move san (translating to “bad blood”) and its associated breast milk disorder lèt gate or lait-passé (“spoiled milk”) appeared on December 29, 1906. Timoleon C. Brutus, a Haitian graduate of the École de Pharmacie d'Haiti, a professor of Natural History in Jérémie, and a historian, wrote of a midwife's famous herbal remedy for a common malady known as “lait-passé,” a malady that was “well-known and widespread throughout the country” (Brutus 1960). Brutus provided a detailed description of the disorder's physical symptoms:

D'un teint décoloré, son visage est pâle, maussade. Le corps amaigri par un jeûne involontaire, devient le siège de quelques petites crises nerveuses, s’ajoutant à d'autres malaises physiques. De larges groupes de taches blanches masquent la figure, la poitrine, le dos et les bras. Les fonctions digestives déséquilibrées ont vite fait du personage un loque pitoyable.
[Her discolored face is pale and sullen. Her body, emaciated by unintentional fasting, becomes the site of several small nervous crises, in addition to other physical pains. Large patches of white spots cover her face, chest, back and arms. Digestive problems further reduce this person to a pitiable rag of her former self.]

He continued by describing the way in which the affliction affected the psychological profile of female patients:

Et par-dessus ces signes expressifs, il se forme un mental qui oblitère l’intelligence et l’énergie accumulées dans une nervosité qui vibre comme au souffle du vent, prémices d’une sorte d’absence, de distraction, de perturbation de jugement. Parfois la malheureuse s’enfuit de la maison, elle gagne la rue. On la dit folle.”

[Beyond these visible signs, a mental affliction obliterates her intelligence and energy in a state of jumpiness in which she vibrates as if exposed to every gust of wind, foreshadowing a sort of absence, distraction, or lack of judgment. Sometimes the afflicted woman runs away from home and takes to the streets. They call her crazy.]
Brutus’ description distinctly labels the disorder as a woman’s condition through his use of feminine pronouns and also lays the framework for an understanding of move san/lèt gate as an interplay between physical symptoms and psychological changes. Furthermore, he posits that the “physical components” of the disease- weakness, weight loss, and rashes- are external manifestations – “signes expressifs” – of emotional woes within. Brutus reduces the visible symptoms of the disorder into a somatization of the mental. He evokes notions of Cartesian dualism, or the belief in a distinct division and differential composition of mind and body, by parsing the symptoms in physical and psychological buckets. His explanation of the causes of the disorder implicate three emotional states in its onset: “colères intenses et réitérées,” “impressions surprenants,” and “emotions agissant” [intense and repeated anger, surprises, and troubling emotions]. When these occur throughout pregnancy, he continues, they can prevent breast milk from properly forming in the mother’s body.

Despite his highly educated status and biomedical training, Brutus never designates lait-passé as a “folk illness” or decries its physical effects as illegitimate. Instead, he acknowledges that it persists as a prevalent disorder that escapes the capabilities of biomedical treatment. It is “soignée par les matrones du temps,” [treated by midwives] while “les médecins officiels avouaient leur impuissance.” [official doctors admit their inability to treat it] (Brutus, 1960).

This common and widespread malady resurfaces on written record under its Creole spelling in three separate locations in Haiti in the 1980s. In 1986, anthropologist Johanne Tremblay conducted a survey of one hundred women in the
city of Varreux, in the Commune of Croix-des-Bouquets (Figure 1). Tremblay inquired about women’s care-seeking behaviors and their perceived efficacy of medication versus local herbal medicine. A majority of women indicated that they would utilize herbal remedies instead of biomedical treatment as the first line of defense against an illness (42 respondents versus 17) (Tremblay, 1995). Tremblay then collected roughly three hundred herbal recipes for specific illnesses or complaints (Table 1). After excluding recipes that didn’t address precisely defined health concerns, she tabulated remedies corresponding to perceived problem as follows:

<table>
<thead>
<tr>
<th>Recettes des feuilles utilisées par les femmes de Varreux, 1987</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>mouë san (mauvais sang)</strong></td>
</tr>
<tr>
<td><strong>grippe</strong></td>
</tr>
<tr>
<td><strong>frédi (refroidissement)</strong></td>
</tr>
<tr>
<td><strong>gonflement</strong></td>
</tr>
<tr>
<td><strong>soins du corps après accouchement</strong></td>
</tr>
<tr>
<td><strong>fièvre</strong></td>
</tr>
<tr>
<td><strong>mai pîe (mal de pied)</strong></td>
</tr>
<tr>
<td><strong>mal de tête</strong></td>
</tr>
<tr>
<td><strong>têt vire (crise de foie ou de nerf), diarrhée, estoma fê mal</strong></td>
</tr>
<tr>
<td><strong>vant fê mal (mal de ventre), gratéï (bouton)</strong></td>
</tr>
<tr>
<td><strong>vomissement, bouton, vermine, dent</strong></td>
</tr>
<tr>
<td><strong>kolik (colique), doulei tay (douleur à la taille), anémie</strong></td>
</tr>
<tr>
<td><strong>rafîchi (rafraîchir), aprê (manque d’appétit), sommeil</strong></td>
</tr>
<tr>
<td><strong>doulei kô (douleur au corps), constipation, mal d’oreille, maladie de cœur, bave de bébé</strong></td>
</tr>
<tr>
<td><strong>avortement, yeux, poitrine, kô red (corps raide ou tétance), brûlure, hernie, inflammation, mal marten (mal de mâchoire) et lavement</strong></td>
</tr>
</tbody>
</table>

Table 1. (Tremblay, 1995)
Of the three hundred recipes provided by women, twenty-five were explicitly for *move san*, more than the number given for flu ("grippe"), fever ("fièvre"), or headache ("mal de tête"). All diagnostic labels were provided word-for-word by the female respondents themselves. This information reveals *move san* as a very real diagnosis in Varreux and echoes Brutus’ assertion that its treatment is best sought through herbal home remedies or consultation with a local *fanm saj* (midwife/herbalist).

In the late 1980s the discourse of *move san* appears again, this time in the urban setting of Cité Soleil, a large, impoverished community in Port-au-Prince. In anthropologist M. Catherine Maternowska’s ethnography of a family planning center, she encountered clients who brought complaints of *move san* to their physicians. Marie-Marthe, a thirty-two-year-old patient who came to the clinic to receive birth control medication, expressed concern that she was afflicted with *move san*. Similar to Brutus’ description of “unintentional fasting,” Marie-Marthe stated that she felt unwell and had lost her appetite. Interestingly, she attributed the cause of the illness to her birth control pills as opposed to malignant emotions or stress. The doctor’s response to Marie-Marthe, if indicative of typical encounters, may explain why women may prefer to seek traditional care for *move san* and *lèt gate*. The doctor immediately dismissed her complaint and denied that the pills could have caused her appetite loss or general discomfort. The physician took no time to further understand the patient’s complaints, delegitimizing *move san* in the eyes of Western biomedicine (Maternowska 2006).
Finally, Dr. Paul Farmer, a physician and medical anthropologist who co-founded the health care nonprofit Partners in Health in the Central Plateau of Haiti in 1987, contributed comprehensive research on *move san* and *lèt gate* in the rural village of Do Kay in the late 1980s. This ethnography served to contextualize the illness in terms of broader social and political conditions in Haiti. In his essay “Bad Blood, Spoiled Milk,” Farmer describes his interview-based fieldwork in Do Kay, a small village that counted a population of 677 in 1985. Do Kay is situated along a small road in the Central Plateau, a rural area in the center of the nation. Farmer interviewed forty-seven mothers of infants eighteen months and younger (this age range was selected because eighteen months is a model weaning age). Of these women, thirty-six, or 77 percent, expressed that they had suffered or were currently suffering from *move san*. Of these thirty-six women, twenty-four cited interpersonal strife as the cause of the disorder, five cited severe shock (*sezisman*), and seven cited other difficult conditions, such as financial struggles or the stigma of poverty (Figure 2) (Farmer, 1988). Of the women who attributed illness onset to interpersonal strife, seventeen of the twenty-four cases involved a family member or partner, five involved a neighbor, and two involved strangers. The common thread that ran through these narratives of causation, however, was consistently exposure to “too much bad emotion.” (Farmer, 1988)
The common narrative of disease progression among informants in Do Kay was that of a disorder of the blood that spreads to a variety of body parts: Skin, uterus, head, limbs, and eyes may all be affected. Eventually, in nursing mothers, the disorder can spread to the breast milk and render it *gate*, or spoiled. If given to the infant, the milk can cause diarrhea and rashes. Farmer chronicles the case of Ti Malou Joseph, a woman in Do Kay who has experienced repeated episodes of *move san*. Ti Malou lived in a tin hut with her partner and eleven children, scraping by through subsistence farming and informal buying and re-selling of goods. She experienced *move san* throughout several of her pregnancies. She explained the cause as stress brought on by domestic violence: “My illness is the result of fighting with the father of my children. He struck me while I was pregnant and rendered my life very difficult” (Farmer, 1988). After her blood turned bad, other physical symptoms set in: back pains, stomach pains, numbness in her leg, and headache.
She describes the way in which the illness “erupted” into *boutons* (the raised skin bumps similarly chronicled by Timoleon C. Brutus). After seven months, she went to a doctor in Mirebalais to receive a consultation, but was told that “nothing was wrong.” When subsequently interviewed, the doctor stated, “Everyone has *move san*! Her blood is ‘bad’ because she needs more folate and iron. Besides, there’s nothing I can do about such disorders” (Farmer, 1988).

After giving birth to twins (one healthy, one stillborn) and suffering bleeding complications throughout the delivery, Ti Malou developed *lèt gate*. A close friend described her milk as “clear as water” and thus spoiled. Instead of pursuing biomedical treatment a second time, she decided to consult a midwife, who prescribed several natural remedies (Farmer, 1988). This pattern of treatment-seeking seems to be fairly representative of Do Kay: of thirty-two women who sought treatment for *move san* (out of thirty-six cases), three exclusively sought biomedical treatment, sixteen sought both biomedical and herbal treatment, and thirteen sought only herbal treatment. These numbers are indicative of a tendency to view herbal treatment as most efficacious in treating the disorder. It is also indicative of the predominance of medical pluralism in Haiti, or the integration of multiple medical domains or frameworks that I will discuss in-depth in Chapter 3.

The modern relevance of *move san* was confirmed by recent studies of reproductive health in Léogâne, Haiti. In a study of breastfeeding in post-earthquake Haiti, researchers Jenny Dornemann and Ann Kelly found that *move san* and *lèt gate* proved to be significant barriers to breastfeeding behaviors. In contrast to Farmer’s research, which focuses on the threat of transferring spoiled milk to an
infant, Dornemann and Kelly highlight another significant health threat brought on by *lèt gate*: the lack of initiation or premature cessation of breastfeeding. In a survey of 1,131 mothers, they found that only 20% of respondents met the World Health Organization and UNICEF recommendation to exclusively breastfeed infants under six months of age (Dornemann, 2012). This means that 80% of mothers will supplement breast milk with another substance, such as powdered milk or porridge (Zalla, 2012). There are many adverse health effects of *bay tete*, the term used to describe non-exclusive breastfeeding, for both infants and mothers, including increased risk of infection and non-communicable diseases (Stuebe, 2009).

Dornemann and Kelly discovered that *move san* is fairly common among women in Léogâne and has increased due to trauma and life stress brought on by the earthquake. Respondents described the disorder as a disturbance in quality of breast milk brought on by interpersonal conflict, jealousy, or poverty. One survey participant noted that if “extreme poverty was no longer a problem, then bad blood would cease to exist.” The documented symptoms echo previous accounts of the illness: bad blood leads to headaches, body aches, *boutons*, and visual impairment. The blood can “meet” and “fight with” breast milk, resulting in thin, watery milk that can cause diarrhea (*lèt dlo*) and *boutons* if given to an infant (Dornemann, 2012). In terms of psychological health, *move san* can render the mother “crazy,” while spoiled milk can bring about mental illness and developmental disabilities in the child.

High incidence of *move san* in Léogâne was linked to the earthquake in addition to other stressors such as financial strains and inadequate maternal nutrition. Dr. Nahida Chakhtouri, an obstetrician and gynecologist who conducted
research on contraception use in Léogâne in 2011, noted that several women described earthquake-onset *lèt gate* to her. “A few women said that they stopped breastfeeding after the earthquake because they believed their milk was no longer good enough,” she explained. This increase could be attributed to trauma of surviving an event as cataclysmic as the earthquake or increased interpersonal and financial woes brought about by the earthquake and its aftermath.

The breastfeeding study reveals two additional phenomenon in relation to *move san*. First, the language used to label the disorder appears to be dynamic across time and space. In Léogâne, the disorder is also commonly referred to as *kolere* (*colère* in French) (Dornemann, 2012). When I asked my Creole professor, Jacques Pierre, about the literal translation of this term, he noted that it means “intense anger.” He also elaborated on a subtle distinction between *move san* and *kolere*: *move san* is the name of the condition itself, the process of blood turning bad, rising, and traveling to various body parts. *Kolere* is, instead, anger that results from the bad blood, an outward behavioral manifestation of the problem.

In a case study recorded by Paul Brodwin, a medical anthropologist who lived for a year and a half in the rural community of Jeanty, near Les Cayes, the terms *indisposition* and *kriz de nè* are additionally employed to describe health problems brought on by strong emotions and the movement of blood.

Brodwin documents the case of Janine, a poor 19-year-old who experienced complications at the end of her first pregnancy. After attending regular prenatal care visits throughout pregnancy, she experienced lower back pain the evening her contractions began. She recounts, “On Friday evening, I felt sick below my stomach,
near my lower back. They [family members attending the delivery] left to find a midwife. Around eleven, I was really beginning to suffer, but I still couldn't deliver the baby. At midnight, I became *indispose*” (Brodwin, 1996). *Indispoze* is a state in which one falls to the ground and is temporarily unable to move.

Janine later went to the hospital, where she was treated for eclampsia (*eklanpsi*), a Western medical diagnosis characterized by high blood pressure during pregnancy that can lead to seizures and death. Janine also labeled her ailment as *eklanpsi*, evidence of the link between Haitian reproductive illness and biomedical discourse about common cardiovascular problems and reproductive medicine. When asked the cause of the *eklanpsi*, however, Janine did not cite high blood pressure. Instead, she noted that the cause was anger, brought on by the fact that her trusted *fanm saj* was not called upon to attend the delivery when her contractions began. It turn, the *eklanpsi* that caused Janine to become *indispose*.

*Kriz de nè*, According to Brodwin’s local informants, is another common consequence of *eklanpsi*. Traditionally, this affliction is associated more often with shock than anger; a common example is a fit of convulsions at a funeral, when one is confronted with the reality of losing a loved one. Still, this term was used alongside *indisposition* by the villagers of Jeanty to categorize Janine’s condition (Brodwin, 1996).

While this ethnography of *eklanpsi*, *indisposition*, and *kriz de nè* do not exactly mirror the onset or course of *move san*, they both demonstrate the vulnerability of pregnant women to conditions involving the perception of changes in blood quality and flow. Interestingly, Janine’s family members and midwife identify *eklanpsi* as
requiring biomedical treatment, while move san requires consultation with a fanm saj (traditional midwife), doktè fèy (herbal doctor), or oungan (Vodou priest). The changing labels of reproductive Haitian conditions of the blood may be representative of new patterns of integration of Vodou and biomedical healing in different communities.

Still, the adoption of the word eklanpsi does not go hand-in-hand with an acceptance of the biomedical description of eclampsia; the village of Jeanty has instead created “a new biomedical category” (Brodwin, 1996). Villagers have taken a biomedical term and given it new, relevant meaning in the context of their lives and beliefs. Similarly, one informant in Léogâne fifteen years later stated “You make bad blood, that can cause diabetes, cardiovascular disease, pressure, sugar” (Dornemann, 2012). Move san is linked to various biomedical concepts related to blood in this statement: the balance of sugar and insulin in the bloodstream and the increase in blood pressure that can eventually damage the heart. Still, the illness is not replaced by or morphed into these terms; it retains its stable place in Haitian medical discourse.

Instead of perceiving move san, lèt gate, and eklanpsi as isolated ethnographic findings or mystical illnesses that exists outside the realm of efficacious biomedical treatment, it is important to consider its enduring presence in multiple locations over the last century (see Figure 1). From 1906 until 2011, written documentation of the condition has produced an illness narrative with fairly consistent etiology and treatment explanations over time. Furthermore, it is a
condition that inflicts considerable suffering and impacts child and maternal health in very profound ways.

B. Pa-pale

*Pa-pale* literally translates to “can’t speak” in Haitian Creole. It is a condition that is most likely to befall Haitian women who have recently given birth. There is little documentation of this illness, but in her book *Mama Lola*, which chronicles the life and beliefs of a Vodou priestess in Brooklyn, anthropologist Karen McCarthy Brown describes a case of *pa-pale* among a Haitian woman living in New York. She had recently had a child who was taken from her by state welfare services, a traumatic experience led to the onset of *pa-pale*. Normally, the condition lasts several months, during which the afflicted mother cannot speak or leave her bed. In the case of this young woman, however, she was found silently roaming the streets of Brooklyn. There is clearly symptom overlap with *indisposition* and Brutus’ account that some women with *move san flee* the house and wander the streets. Treatment for *pa-pale* is sought among Vodou healers; it is a “disease of that [Vodou] world” (Brown, 1991). In Karen McCarthy Brown’s case study, the woman is cured by a mambo, or Vodou priestess, who feeds and clothes the woman and takes her into her bed until she is cured.
C. Pèdisyon

The Haitian reproductive illness pèdisyon is closely linked to perceptions of infertility among women of childbearing age in Haiti. Pèdisyon describes a condition in which an unborn child remains trapped in the mother’s womb and pa ka fèt (can’t be born) (Murray, 1976). Furthermore, the blood supply that would have normally have been diverted to nourish the growing fetus “bursts and escapes” and the infant shrinks. The child then remains tied to the womb to prevent it from growing.

Each month, the woman experiences vaginal blood flow; however, this is unique to pèdisyon and distinct from menses in that it lasts several days longer. The condition can persist for years and is best treated by a Vodou healer, who can “untie” the child from its position on the womb (Brown, 1991). Then, the baby will grow again and the woman will resume a normal pregnancy. In Mama Lola, Karen McCarthy Brown notes in this case, if the woman has had multiple sexual partners during her time in pèdisyon, she is able to name the father of her child (Brown, 1991). However, if the woman reaches menopause in the condition, the baby will remain tied to the womb for the remainder of her life (Murray, 1976).

Before analyzing the various causes of the condition, it is interesting to examine the etymology of the word pèdisyon itself. Gerald Murray, an anthropologist who studied the condition in Haiti’s Cul-de-Sac Plain in the 1970s interprets the word as a “Creolized” cognate of the French perdition, defined by Larousse as à être ruiné, or “to be ruined.” (“Perdition,” 2013). This categorization evokes the unsuccessful nature of the intended pregnancy and also the emotional
and physical conditions that can cause the disorder. An alternative etymology is the Creole phrase “pèdi san,” or “losing blood,” which describes the initial “burst” of blood and subsequent irregular patterns of blood loss during pèdisyon (Singer, 1988).

Through the synthesis of Murray’s ethnography and Merrill Singer, Lani Davison, and Gina Gerdes’ account of pèdisyon in Jacmel, a complex illness narrative unfolds, one involving multiple etiologies and treatments. Murray divides the possible causes of pèdisyon into five categories: frèdi (cold), lwa, the dead, lougawou, and sorcery. Frèdi, or cold, refers to exposure to low temperatures, which can cause pregnant women to fall into pèdisyon. This occurs when pregnant women go out in the cold or lift heavy loads; in the case of the latter, bones in the woman’s abdomen are displaced and the cold slips through the opening. The other four categories refer to Vodou beliefs involving the transfer of illness from one agent to another. Lwa are Haitian spirits who, when angered, may tie the child to the womb. Similarly, when a child does not properly mourn a deceased parent, the spirit of the mother or father will tie up his or her grandchild. The lougawou are community members who turn into malevolent animals at night who will suck the blood of the unborn child. Finally, a jealous or angry neighbor may hire an oun gan to perform sorcery on a pregnant woman and cause her to fall into pèdisyon.

Although a woman may suspect she has fallen ill, an oun gan or mambo is necessary to confirm the onset of the disorder and determine the cause. Once this occurs, there are several treatment options depending on type of pèdisyon. In the first case (cold), the condition can be reversed by a massage from a fanm saj; in
other cases, the oun gan will specify necessary behaviors to remedy the condition. A doctor may be consulted in cases of extreme physical pain (Murray, 1976).

Through their fieldwork, Singer et al provide several additional explanations: a fall or blow, which displaces the embryo, and difficult manual labor. Lucienne, a domestic servant and mother of five, described her pèdisyon as a consequence of prolonged manual labor: “I have pain in my back and cramps in my legs. Sometimes when I am walking, all of a sudden I can’t bend. And I feel something like a ball under my stomach on the right side, it hurts. I work too much bent over, it’s hard” (Singer, 1988). The physical difficulties of Lucienne’s daily work, coupled with her responsibility for five children, led to increased susceptibility to pèdisyon.

Both of these anthropological accounts note that pèdisyon is understood as distinct from local definitions of miscarriage. However, the illness narrative documented by Singer, Davison, and Gerdes in Jacmel incorporated two biomedical terms into the understanding of pèdisyon: fibròm and emoraji. According to biomedical knowledge, fibròm, or fibroids, are noncancerous growths on a woman’s uterus that develop during childbearing years. The most common symptoms are prolonged periods, heavy menstrual bleeding, pelvic pain and frequent urination. In rare cases, a fibroid can outgrow its blood supply, at which point it begins to die, a process which can induce pain and fever. Fibroids can also increase risk of infertility and miscarriages (“Uterine Fiboids,” 2011). In relation to pèdisyon, a fibròm is perceived as a “hard ball of spoiled blood” that can result from the condition (Singer, 1988). The child can turn into a fibròm; alternatively, a fibròm can form and compete with the child for blood in the uterus. If the fibròm absorbs all the
blood, the child tied to the womb will further shrink and die. According to
informants in Jacmel, only doctors can successfully treat fibrôm through surgical
intervention.

Similarly, the word emoraji, or hemorrhage, is used to discuss the blood loss
that occurs during pèdisyon. Hemorrhage is the second most prevalent cause of
maternal death in Haiti, after eclampsia accounting for 22% of maternal deaths
(Prins et al., 2008). In Jacmel, the label of this common and often fatal maternal
affliction is introduced into the discourse surrounding the existing illness category
of pèdisyon.

Another possible interpretation of pèdisyon is a prolonged state of infertility,
especially if the condition endures until menopause. As long as a woman remains in
pèdisyon, she will not be able to become pregnant; if she is cured, the child who was
previously tied will be brought into the world. Pèdisyon may thus function to reduce
stigma attached to the inability to conceive in Haiti (Lassiter, 1995).

If pèdisyon can be caused by the burden of excess work and is related to the
concept of infertility, then it is no wonder that other anthropological accounts link
female hardships in Haiti to the inability to reproduce. Anthropologist Johanne
Tremblay details the story of Polamise, a thirty-three-year-old woman in Varreux
who experienced a temporary period of infertility during her young adulthood.
Polamise grew up in extreme hardship; between the ages of ten and eighteen, she
lived as a restavèk in her aunt's house in Port-au-Prince. A restavèk is a child slave,
forced to work long hours and perform physically demanding labor for no pay. They
are often female and usually sent from rural, impoverished households to live with
relatives in the capital city for the duration of their youth. There are an estimated 300,000 restavèk in Haiti (Loney, 2010). Polamise recounts the difficulty of her youth: “Ma tant mwen, se li menm ki pran tout kob komès mwen an, li pa vle pou’m anyen nan vi mwen.” (My aunt took all my money earned in commerce. She didn’t want me to achieve anything in life). Years later, Polamise blames her aunt for the “infertilité” she experienced, as well as an illness suffered by her first child (Tremblay, 1995). The story of Polamise documents the link between life hardships, physical labor, destructive relationships, and subsequent fertility problems that mirrors both physical and Vodou-related causes of pèdisyon.

D. Matris Deplase

Wandering womb disorder, or matris deplase, is an early postpartum condition in Haiti that leads to health outcomes such as dizziness and confusion. It has been documented primarily in immigrant populations but was also cited as a chief complaint by Singer, Davison, and Gerdes in their assessment of pèdisyon in Jacmel (Singer, 1988). In contrast to the other three illnesses outlined in this chapter, it cannot afflict pregnant women; instead, it strikes women who have just given birth. It is said that after nine months of close proximity with the baby, the womb misses its companion after childbirth and searches the body to find it. As explained by Haitian immigrants in New York in the 1980s, “when the child exits the womb, the womb senses a sudden, radical, violent emptiness” (Snow, 1985). After detaching from its normal location, it moves throughout the mother’s body,
sometimes settling in the limbs of the mother (Snow, 1985). The weak condition of the mother following birth is often attributed to a wandering womb (Lassiter 1995). Treatment is two-fold. First, the womb must be returned to its proper location via a massage by a *fanm saj*. In addition, the mother must “fill” the emptiness of the womb with nutrient-dense food in the four to five days following childbirth (Snow, 1985). The nourishing properties of food substitute for the emotional proximity of the child in the womb.

Interestingly, the idea of a wandering womb or uterus was present in Ancient Greece, when Hippocrates popularized the belief that the uterus could move about the body and cause illness. The Greek word *hysterus*, or uterus, forms the basis for the modern term *hysteria*, a word which describes various physical manifestations of intense emotions in women including displaced reproductive organs (Gilman, 19933). In Haiti, the condition is indicative of the strong bond that forms between mother and child during pregnancy, resulting in the womb’s emptiness and longing. It is also indicative of the physical hardship of the act of childbirth, which can result in this violent and sudden detachment of the womb.

V. Embodied Female Trauma

Although the conditions chronicled above have distinct names, there are multiple ways in which they overlap. All are caused by shock, trauma, anger, or demanding physical work, and most lead to disturbances of internal organs that play a key role in childbearing (blood and uterus). Furthermore, most fall outside
the realm of biomedical treatment, due to both Haitian women’s’ acknowledgment that these conditions are best treated by an herbalist and doctors’ inability to legitimize these conditions or recognize the important space these disorders inhabit in the sphere of Haitian medicine. Whatever the acute cause, symptoms, or best treatment, these stable disorders are all manifestations of the difficult life conditions women face and the health risks they incur through the dangerous process of childbirth.
Chapter Two

Poto Mitan and the “Axis of Gender”

“Fanm Ayisyen” pa Feliks Gregori

I
Fanm ayisyèn se yon machin
Fanm ayisyèn se yon rasin
Yon rasin ki djanm
Fanm ayisyèn yo genyen nanm

II
Fanm ayisyen yo bèl
Anplis tou yo pa rebel
Fanm ayisyèn yo genyen fyèl
Jiskaske yo al nan syèl

III
Yo travay chak jou pi di
Mache nan tout lari
Pou jwenn lanouriti
Nan yon peyi k ap vin pi di

English translation

Haitian women are an engine
Haitian women are the roots
The robust roots
Haitian women have strength

Haitian women are beautiful
Furthermore they don’t rebel
Haitian women have stamina
Until they go to heaven

They work harder each day
They walk the streets
To find food
In a country that gets more and more difficult
This excerpt from the poem “Fanm Ayisyen” by Feliks Gregori pays homage to the typical Haitian woman, a model of patience, resilience, and perseverance who is the “potò mitan”, or pillar, of the family and society. It cites the important role women play in Haiti’s economy – they *travay chak jou*, or work each day-- and praises women for their primary role in ensuring the development and educational progress of their children – they *jwenn lanouriti*, or find food. However, this poem also displays the tendency to gloss over this persona, focusing on the steady, stoic nature of women (as *bèl* and *djanm*, or beautiful and robust) while masking the harsh reality of the female condition in Haiti. The exceptional resilience of women is lauded, yet the root causes of the burden and suffering they face, as well as the enormous potential to improve their situation, are ignored. Haitian women *pa rebel* or are not rebellious, according to the author: they accept the burden of their situation and muster up *fyèl*, or stamina, each day.

By accepting the female condition in Haiti and focusing only on the strengths of character it demands, one risks isolating the issue from the larger picture: the way female oppression interacts with poverty and political instability to powerfully shape women’s and children’s health outcomes. As Danièle Magloire, a Haitian women’s rights advocate and director of the organization EnfoFanm, noted, “La différence fondamentale entre Haïti et ailleurs est le poids de cette prise en charge dans un pays où les infrastructures de base sont déficientes ou quasiment inexistantes, où la pauvreté frappe la très grande majorité. [The main difference between Haiti and elsewhere is the weight of women’s caretaking in a country where the basic infrastructure is deficient and basically inexistente, where poverty
affects the majority of people] (Magloire, 2010). This interaction contributes to a vicious cycle of poverty, violence, and adverse psychological and reproductive health outcomes.

I. Structural Violence, Poverty, and Gender

The extent of gender inequality in Haiti can be examined through the framework of structural violence, an anthropological term that refers to the way in which social forces shape health outcomes. Dr. Paul Farmer describes how the “axis of gender” figures prominently into the model of structural violence. Male-dominated legal and political institutions contribute to the inferior status of women in most countries around the world. This, in turn, shapes adverse health outcomes—high rates of maternal mortality, pregnancy complications, and certain infectious diseases (Farmer, 2003). For instance, in Sub-Saharan Africa, 60% of HIV patients are women, a statistic that in a structural violence framework can be attributed to rape, lack of female education, and barriers to contraception and treatment, all of which are coupled to unequal male/female power dynamics. Structural violence does not affect all women equally; instead, poor women suffer greater health risks than wealthy women.

II. Women’s Educational, Economic, and Caretaking Realities in Haiti
In Haiti, women – especially poor women – face significant inequalities and expectations that shape maternal health outcomes and psychological well-being. The “Axis of Gender” present in Haiti consists of a set of educational, economic, and caretaking disparities. In the eyes of the law, women have faced severe inequality in Haiti. For example, the Haitian Civil Code, which defined human and family rights in 1825, stated that women owed obedience to their husbands, and men held sole legal authority over children and household. Furthermore, according to this code, a woman could not call the police or take legal actions unless given permission by her husband. These laws persisted until 1982, when a series of decrees allowed for increased marriage rights for women (Perrault, 6). Rape was only formally criminalized in 2005. Still, certain forms of legal discrimination persist today. For instance, marital rape is not recognized as a crime, women do not have rights to land ownership, and sexual harassment in the workplace is not criminalized (Human Rights Watch, 2011).

This lack of legal protection is echoed in the everyday discrimination faced by women in Haiti. In 1990, the Population Crisis Committee rated the condition of women in Haiti the worst in the Western Hemisphere. (Maternowska, 2006). The common term poto mitan refers to a double expectation of Haitian women- not only are they the backbone of the family, but they are also the backbone of the Haitian economy. According to a 2006 USAID report, over 75% of informal sector positions are held by women. These positions include commerce and trade and altogether account for 85% of Haiti’s total economy. Many women work as madam sara, or market vendors (James, 2010). Haiti has the 2nd highest proportion of economically
active women among all developing nations, although wage discrimination exists (Gardella, 2006). Despite their active contributions to the Haitian economy, women do not have equal access to education. 43.3% of Haitian women are illiterate, compared to 33.4% of men. While primary and secondary school enrollments are about equal between girls and boys, many more boys progress through school after the age of 16 (Gardella, 2006). This is due in part to the fact that 32% of Haitian women will have a child before age twenty and must discontinue school when pregnant (Gardella, 2006)(Magloire, 2010).

Aside from playing an essential role in the Haitian economy, women are expected to fulfill primary caretaking duties at home. The average Haitian woman will give birth to five to seven children, due largely to lack of access to contraception –only 22% of married women in Haiti regularly use contraception-- and beliefs that childbearing is a woman’s duty to her husband (Magloire, 2010)(Gardella, 2006). Women are responsible for feeding their families and taking care of household chores. Dr. Catherine Maternowska notes, “The physical effects of women’s tasks-generating income; maintaining the house in clean and working order; washing and ironing clothes; finding, preparing, and providing food; caring for the young; and typically tending to extended kin- are heavy and are invariably concentrated during women’s childbearing years.” (Maternowska, 2006). Food insecurity linked to poverty may contribute to malnutrition among women, coupled with the expectation that women feed their husbands before they feed themselves.

The reality of this dual burden of women in Haiti, combined with a lack of fully equal legal recognition, manifests itself in poor maternal health outcomes that
are exacerbated by poverty. Furthermore, daily hardships faced by women contribute to collective trauma that factors prominently into illness expression.

III. Violence Against Women

Aside from everyday hardship and widespread gender inequalities, domestic and sexual violence are also highly prevalent in Haiti. Gender-based violence is historically rooted in a number of political regimes during which the state used rape as an oppressive weapon. During François and Jean-Claude Duvalier’s dictatorships, rape was often used to silence political enemies (Human Rights Watch, 2011). Additionally, in her book Democratic Insecurities, anthropologist Erica Caple James traces human rights abuses against Haitian women back to the 1991-1994 period of military rule, when a coup d’état ousted democratically elected Jean-Bertrand Aristide and replaced him with General Raoul Cédras (James, 2010). This period was marked by thousands of killings and a mass migration of refugees to the United States. James argues that the military regime employed a “terror apparatus” through which they created a culture of fear through rape, beatings, forced incest, and forcing illegally imprisoned women to have sex in exchange for release (James, 2010). Since the end of Cédras’ rule in 1994, sexual violence has remained widespread in Haiti, flaring up during periods of political unrest.

In the last ten years, a number of studies point to astoundingly high rates of violence against women in Haiti. One study conducted by the Inter-American Development Bank in 2006 estimated that one-third of Haitian women were victims
of sexual violence at some point in their lives (Inter-Agency Standing Committee, 2010). In a 2005-2006 EMMUS IV study, over 25% of Haitian women reported physical violence since the age of 15; 16% of all women reported an incident in the last twelve months, and around 30% of victims were targeted by their husband or partner (Human Rights Watch, 2011). Still, accurate rates are difficult to measure due to stigma and aforementioned lack of full legal recognition.

The climate of violence towards women that has existed for several decades may have been exacerbated by post-earthquake conditions. The magnitude 7.0 earthquake that shook the South of Haiti on January 12, 2010 killed 220,000 people, injured 300,000, and left over a million people homeless. Three years later, 358,000 people still live in camps (“Survey,” 2012). Rates of sexual violence in camps are especially high and are linked to harsh living conditions such as limited access to food, water, and adequate sanitation. An NYU School of Law’s Center for Human Rights and Global Justice Clinic 2011 report surveyed 365 households in four IDP camps in Port-au-Prince and found that 14% of households reported sexual violence against one or more family members since the earthquake. 86% of these victims were women, and most were in their early twenties, or peak child-bearing years (the average Haitian woman gets married at age 21)(CHRGJ, 2011)(Gardella, 2006). This increase in sexual violence also ushered in marked changes in anxiety levels.

As shown in Figure 1, 70% of respondents stated that they were more worried about sexual violence after the earthquake than they were previously. Researchers also found a correlation between food insecurity and sexual violence, illustrating the
complex relationship between physical vulnerability, poverty, and violence (CHRGJ, 2011).

Figure 1. Data from CHRGJ, 2011.

Sexual violence in Haiti is linked closely to reproductive health. In fact, pregnant women are especially at-risk for suffering from sexual and domestic violence (Kang, 2011). Pregnant women are less able to defend themselves and the reality of a new baby may introduce new stressors into relationships. A 2003 study conducted in the Artibonite Valley in Central Haiti surveyed 200 women seeking prenatal care at a local dispensary (Small, 2008). 44% of those women had experienced either intimate partner violence or non-partner violence in the six
months preceding the study. 77.8% of these cases constituted intimate partner violence, a startling statistic which further highlights the often unequal power dynamics in romantic relationships.

Sexual and domestic violence is also closely associated with poor reproductive health outcomes and mental health outcomes. First, sexual violence leads to unwanted pregnancy, especially in a country in which most women lack access to contraceptives. Larger families impose greater burdens on women, exacerbating the cycle of female suffering in Haiti. Once pregnant, continued abuse can lead to a host of health problems. In the Artibonite Valley study, female victims of physical abuse reported significantly higher levels of symptom distress during pregnancy as compared to non-victims, including vaginal bleeding, abdominal pain, heartburn, and back pain (Small, 2008). Another study conducted in 2000 found a strong correlation between domestic abuse and adverse reproductive health events, including sexually transmitted infections (STI), unwanted births, or stillbirths (Kishor, 2006).

Furthermore, many studies point to the devastating long-term psychological consequences of experiencing domestic and sexual violence. Although no studies conducted in Haiti explicitly link violence with mental health, a number of studies in multiple countries have found strong correlations between incidence of violence and adverse psychological outcomes. Research in America suggest that about one-third of sexual assault victims develop Post-Traumatic Stress Disorder (PTSD) at some point in their lives and 1/3 contemplate suicide (National Center for PTSD, 2007). Many women also deal with feelings of guilt, shame, and anger. Other
reports demonstrate the ways in which these psychological problems can be linked to reproduction. A study in Tanzania found that pregnant women who had been abused were much more likely to meet criteria for anxiety, depression, and Post-Traumatic Stress Disorder than pregnant women who had no history of sexual or domestic violence (Mahenge, 2013). In addition, a previous history of sexual violence may serve as a risk factor for postpartum stress (Zimmerman, 2008). A birth may serve as a trigger for past traumatic memories of sexual abuse and lead to adverse postpartum mental health outcomes (Reynolds, 1997). Haiti’s high rates of domestic and sexual violence are undoubtedly related to poor physical and psychological maternal health outcomes.

IV. Women’s Health in Haiti

Related to the issues of legal discrimination, economic demands, caretaking, and sexual violence, Haitian women face poor reproductive health outcomes relative to other developing countries. The island nation has the worst maternal mortality rate of any country in the Western hemisphere: 630 per 100,000 women who bear children die during delivery. For reference, this is triple the next worst rate in the hemisphere (Bolivia) and about 26 times the rate in America (“Good Health Care,” 2010). For women who do survive childbirth, an abundance of pregnancy and birth complications – eclampsia, obstructed labor, and malnutrition, to name a few – impact the health of both mothers and their newborn children. In 2000, the instance of low birth weight was estimated at 15% nationally and the infant mortality rate was 74 infant deaths per 1000 live births (Alexandre, 2005). A popular Creole
proverb states “Pito dlo a tonbe, kalbas la rete” (Freeman, 1998). This literally translates to “better that the water falls and that the gourd remains,” but its meaning refers to the belief that it is preferable to lose the baby than have a mother die in childbirth. This proverb reflects the way that poor child health outcomes have normalized the concept of infant mortality in Haiti.

Access to health care is restricted, especially in rural areas, and this presents a series of obstacles that prevent women from accessing proper prenatal care or obstetric services. A 1998 study by the Division of Family Health within the Minnesota Department of Health offers a model coined the “three delays” model to investigate the problem of maternal mortality in Haiti. The model holds that there are three main stages at which substantial obstacles to accessing obstetric care present themselves. First, considerable delays exist in deciding to seek appropriate medical care for an emergency. Next, women are not able to reach an appropriate obstetric facility on time. In rural parts of Haiti this is especially true; 34% of the rural population needs two hours or more to reach a health care facility (Alexandre, 2005). Lastly, women may not receive adequate care even when a facility is reached (Barnes-Josiah, 1998). The study examined in depth twelve cases of maternal mortality and found that eight of these women experienced the first delay (deciding to seek care) and seven experienced the third delay (adequate care) during the course of their pregnancies. Only seven of the women made a prenatal care visit, and these trips were made exclusively for medical problems as opposed to general care (Barnes-Josiah 1998).

Additional studies have highlighted the high incidence of pregnancy
complications within Haiti and suggested a correlation with lack of prenatal care.

A 2007 self-report study interviewed over 400 women in the Grand Anse region of Southwest Haiti, where the maternal mortality ratio is thought to be highest based on the rural setting and scarcity of health care facilities. While about 88% of women had attended some sort of prenatal care visit, only 7% of women reported a consultation with a doctor and only 3.2% of women delivered in a hospital. In terms of pregnancy complications, over half of the women reported either great pain, bleeding during pregnancy, bleeding post delivery, or fever during or post delivery. This suggests a high incidence of possibly traumatic birth complications and low access to health care, although it is not possible to imply causation between the two (Anderson, 2007).

Another study sought to measure prenatal care utilization in rural and urban areas in Haiti through survey data. It was found that in both populations, prenatal care use was positively correlated with education level. While urban mothers met the WHO recommendation, on average, of four prenatal care visits, rural mothers fell slightly short with an average of 3.78 expected visits. The type of prenatal care facility or attendant was not specified by this study (Alexandre, 2005).

The problem may not only lie in the access to care but also in the seeking of care. A report on health-seeking behavior of pregnant women in the rural Artibonite valley found that 25% of women with pregnancy complications did not seek health care in a nearby health center. Of those who did, 37% report being dissatisfied with care, a statistic which may explain the third delay in Barnes-Josiah’s study and even the first: women may be discouraged from seeking care.
during subsequent pregnancies (White, 2006).

Overall, prenatal care use in Haiti seems to vary considerably depending on a number of sociodemographic factors, but the incidence of pregnancy complications nationally remains high. A lack of access to care or quality care as defined by the “three delays” model likely plays a role not only in maternal and infant mortality but also in the high self-report prevalence of bleeding, great pain, fever, and other complications during and after birth. Delays in accessing health care may result in greater unnoticed complications during pregnancy that become full-fledged labor emergencies that impact mothers’ physical and psychological health.

V. Re-examining “Poto Mitan”

“À cause de la manière dont les relations avec les hommes se passent, on est dans un cercle vicieux” – Danièle Magloire (Magloire, 2010)

[“Due to the nature of the relationship between men and women, we are in a vicious cycle”]

The popular discourse of poto mitan in Haiti is valuable in recognizing the myriad ways in which Haitian women contribute to society. However, it is potentially dangerous in the way it ignores the day-to-day reality of women in Haiti. The phrase risks normalizing the extraordinary hardships Haitian women face, hardships that carry serious health implications. I posit that due to the unrealistic share of work placed on women and common violence they experience, suffering and trauma are widespread and can be embodied and expressed as a number of reproductive illnesses such as move san. Thus, in treating reproductive illnesses, it is also important to consider the structural violence that contributes to their
symptoms. If Haitian women are the pillar of society, it is important to take two steps back and ask how Haiti can better support these pillars—what legal and health interventions are necessary to ensure that women are valued and healthy.
Chapter Three

Bad Blood and Blood Pressure: Medical Pluralism in Haiti

As evidence by descriptions of reproductive illnesses in Chapter 1, there are many different treatment remedies specific to each disorder and context. For instance, lèt gate is best treated by a fanm saj, a midwife, or an ounangan, a Vodou priest. On the other hand, eklanpsi brought on by shock or anger was perceived as a maladi doktè, a “doctor’s sickness” that required immediate biomedical attention. (Brodwin, 1996). These examples are indicative of a complex medical pluralism, or the complementation and integration of multiple medical systems, that defines health discourse, health-seeking behavior and treatment in Haiti. In the Haitian context, these two systems are Western biomedicine and “traditional” Haitian medicine, which may or may not be explicitly linked to the Vodou religion but almost always draw on Vodou conceptions of mind and body that are deeply embedded in Haitian culture. Although biomedicine and Vodou are occasionally in tension with each other, the two systems have come to co-exist peacefully and serve different purposes. This chapter explores the relationship between biomedicine and Vodou medicine in Haiti and how this pluralism impacts the way women seek treatment for reproductive health problems.

The idea of medical pluralism in relation to reproductive health in Haiti is hardly a novel approach. Haiti’s synthesis of multiple medical systems dates back to its French colonial period. The first French settlement on the island was established in 1625, and by the mid-eighteenth century the colony, named Saint-Domingue, was the richest of the French empire, earning the nickname the “Pearl of the Antilles.”
The health care infrastructure in Saint-Domingue was based on the French medical system at the time and was regulated by the local government, made up of a colonial assembly, governor, military officers, and provincial officials in the western, southern, and northern provinces. The medical system was headed by “médecins du roi,” or royal physicians, who oversaw the licensing of newly arrived surgeons, physicians, and midwives. Many French-trained surgeons (almost all male) were enticed to Saint-Domingue for the absurdly high pay they could earn as plantation surgeons, doctors who tended to births and health needs of slaves. French governors were invested in maintaining a high birth rate among slaves and thus were willing to pay these plantation surgeons more than even top-ranking surgeons earned.

Aside from plantation surgeons, three other groups of care providers were responsible for pre and postnatal care and childbirth. First, midwives trained in France traveled to the colony to provide care. Historian Karol Weaver describes an expedition of midwives sent by the royal crown in 1764. Despite these midwives’ formal training in France, they were criticized by royal physicians for their lack of knowledge of health patterns thought to be unique to local climate and Creole body (Weaver, 2005). Free women of color also practiced in cities, but due to pervasive racial hierarchies this was frowned upon by authorities.

Finally, enslaved “accoucheuses”, or midwives, also attended many births of female slaves. A law issued in 1725 required that all deliveries be supervised by a surgeon; in spite of this, many slave midwives grew well-respected for their expansive local knowledge and years of expertise (Weaver, 2005). Thus, Haitian
obstetrics operated through multiple systems: through French medical knowledge applied to the specific context of Saint-Domingue, as well as through traditional slave midwives’ knowledge passed down through generations. Even the French medical system combined local knowledge with traditional European techniques: Royal physicians accepted indigenous herbs and vegetables as more efficacious than certain French remedies given the Caribbean climate (Weaver, 2005).

Three hundred years later, the nation of Haiti still comprises multiple health systems. Western biomedical care is provided through three types of institutions: the Ministry of Public Health and Population (MSPP), private practice professionals, and nonprofits (Nicolas, 2010). Public health care spending is minimal; the government allots about $46 per capita on health care (the U.S. spends over $7000 per capita in comparison) (WHO, 2013)(Hixon, 2012). Since about 77.5% of Haitians live on less than two dollars a day, paying for health services out of pocket poses a significant, and often impossible, economic burden for individuals. Consequently, about 70% of health care is provided by non-governmental organizations (NGOs); according to the MSPP website, there are currently 161 nonprofit organizations providing health services in Haiti (Ramachandran, 2012)(MSPP, 2013). Recent data indicates that there are 49 hospitals, 217 health centers, and 371 health outposts serving ten million people in Haiti (Nicolas, 2010).

Biomedical obstetric care is limited, especially in rural areas. A 2011 United Nations Population Fund report found that there are only 221 obstetricians in the country. Only 26% of births are attended by health professionals with biomedical obstetrics training (this includes physicians, nurses, midwives, and skilled birth
attendants) (UNFPA, 2011). Global health agencies mark a clear distinction between birth attendants with biomedical “skills,” or skilled birth attendants, and ones with local knowledge but no formal training, traditional birth attendants. According to 2005 United Nations statistics, about 30% of urban births take place in a public facility, roughly 15% take place at a private or NGO facility, and over 50% take place at home. In rural areas, the percentage of home births exceeds 80%. Furthermore, there is a huge discrepancy between urban and rural areas in terms of who is attending deliveries. In cities, doctors preside over about 30% of births, trained midwives attend about 15% of births, and about 50% of births are presided over by an unidentified “other,” which includes family members and traditional birth attendants. In rural areas, these “others” are responsible for over 80% of births (UNFPA, 2011).

Driven by international momentum to fulfill Millennium Development Goal number five, which calls for a worldwide reduction in maternal mortality by 75% by 2015, the Haitian government has recently prioritized reproductive health initiatives. In 2008, the MSPP and the Pan-American Health Organization (PAHO) launched the Soins Obstétricaux Gratuits (SOG), or Free Obstetric Care Project, with financial support from the Canadian International Development Agency (CIDA). The goal of the project is to provide all pregnant women (especially low-income women) with free health care, including four prenatal visits, free deliveries, postnatal visits, and nutritional assistance. After experiencing setbacks in the wake of the earthquake, the program refocused its efforts and expanded to 63 participating
institutions in 2010. The program has since treated over 70,000 women and newborns.

Early indicators demonstrate the program’s success in reducing maternal mortality: out of 22,103 deliveries entered in the SOG database by 2009, only twenty-two resulted in maternal death, representing a rate of 100 deaths per 100,000 live births, or one-sixth the national average (PAHO, 2009). Data also suggest that SOG is changing the care-seeking behavior of women: more women are giving birth in institutions, even if their previous deliveries have taken place at home (PAHO, 2009). In addition, surgical intervention is on the rise; among beneficiaries of SOG, 10% underwent C-sections, as compared to the national average of 3% (PAHO, 2009). The program has recently expanded to incorporate neonate health as well; the Soins Infantiles Gratuits (SIG), or Free Child Care Project, now aims to provide free health care to children under age five. Both of these programs will continue to mobilize millions of dollars of funding to provide biomedical care for pregnant women, new mothers, and their infants.

A 2011 PowerPoint prepared by the PAHO and the MSPP to provide an overview of SOG and SIG includes several slides on “Obstacles à l’accès aux soins,” or “obstacles to health care access.” Under the “cultural” subheading, the slide reads “Recours à la medicine traditionelle, 70% du temps,” or “[Women] resort to traditional medicine 70% of the time,” citing a 2005 MSPP report (Graaff, 2011). This categorization of traditional medicine as an obstacle to biomedical care is somewhat problematic; it implies that women do not seek biomedical care because of belief in traditional medicine, when in reality these two systems are not perceived
as mutually exclusive (Brodwin, 1996). This explanation also partially disguises issues that present real obstacles to women seeking obstetric care: namely, lack of access to facilities and lack of resources to afford services (Kohler et al., 2012).

What exactly is “traditional” medicine in Haiti? This broad category refers to cultural perceptions of body, illness, and treatment. These perceptions are inextricably tied to the Vodou religion, a blend of traditional West African beliefs and Catholicism unique to Haiti. Individuals in Haiti subscribe to Vodou beliefs on a wide continuum; many Haitians identify formally with Catholicism or Christianity but still incorporate Vodou beliefs into their lives, while others are active Vodouisants who attend ceremonies and practice openly. In the same way that medical pluralism defines the health landscape in Haiti, religious pluralism is also widespread. During our Standard of Care interviews in Léogâne, for instance, few people explicitly mentioned Vodou healers or ceremonies as a solution to health or social problems; however, there were frequent mentions of herbal remedies that fall under the umbrella of the Vodou health framework. Haitian author Layenèk Ibon describes the way Vodou is synonymous with culture in Haiti:

“Nou pa gen Vodou yon bè, e pèp la yon lòt bo. Vodou a deleye lan tout lavi pèp la. Pèp ayisyen an jwenn li depi li lan vant, li jwenn li tankou premye model ki paret sou je l, lè l ap grandi. Li jwenn li tankou premye lèt li souse pou edikasyon li ak pou jan li konprann lavi sosyete a ak tout reyalite ki sou tè a.”
[You can’t separate Vodou on one side and Haitian people on the other. Vodou is dissolved in the lives of the Haitian people. Haitians experience Vodou in the womb, as the first model they see when they are growing up. They experience it as the first milk they suck, as their education, and as the way they understand social life and every truth in the world.]

Vodou discourse fundamentally shapes perceptions of health and illness. Vodou is based on a “cosmocentric” perspective of the world, in which each person inhabits a space within a larger network of lwa (spirits), kin relations and social relations (Khoury 2012). Illnesses may have natural or supernatural causes. For instance, an example of a natural illness, or “maladi Bondye” (God’s sickness) would be the “pèdisyon frèdi” discussed in Chapter 1, which occurs when a pregnant woman is exposed to cold. On the other hand, pèdisyon lwa occurs when an angered Haitian spirit ties an unborn child to a pregnant woman’s womb. This is an instance of a supernatural or “sent” illness, known in Creole as maladi bon lwa. Illness is viewed as a dynamic concept that can be transferred among humans, animals, and the earth. For instance, Vodou priest (oungan) and musician Erol Josué noted that one treatment of lèt gate involves transferring the spoiled milk from the mother to ants. The mother should express the spoiled milk onto an anthill (nich fousi); ants will absorb the milk and thus the illness. An alternative treatment involves putting lemon and garlic on the mother’s breasts; this remedy similarly posits that the illness will leave the mother and instead inhabit this new, natural space (Zalla, 2012).
In a Vodou framework, there are several levels of healers who can diagnose and treat illnesses. *Oungan* and *mambo* are initiated Vodou priests and priestesses who are often sought out to provide diagnoses and prescribe treatment. Treatment may also involve work of an *oungan* or *mambo* on behalf of the sick person; for example, he or she may transfer a malady to an animal. Next, *doktè fèy*, or *medsen fèy*, provide expertise on herbal remedies to cure a number of illnesses. Lastly, *fanm saj*, or traditional midwives, tend to the needs of pregnant women and are also knowledgeable about herbal remedies (WHO, 2010).

Biomedical treatment and traditional treatment in Haiti are systems that complement each other much more often than they come into tension. Anthropologist Paul Brodwin noted a “paradox of biomedicine” in the community of Jeanty where he conducted fieldwork: “Despite its [colonial] origins, biomedicine does not exist as a bounded ‘health care sector’ in isolation from other forms of therapy, and it has not subverted the local healing system.” (Brodwin, 1996). Similarly, the prevalence of traditional healers does not discourage Haitians from obtaining biomedical treatment. A 2012 study in Haiti’s central plateau found that Vodou beliefs did not prevent individuals with mental health problems from seeking care at local clinics. Through conducting 31 semi-structured interviews in the community of Lahoye, researchers observed that many perceived mental health problems were attributed to supernatural causes, specifically possession by a lwa. Despite this Vodou etiology, individuals with mental illness still sought biomedical treatment; in fact, it was not uncommon for *oungan* to refer people to hospitals for additional care (Khoury, 2012). It is entirely normal in Haiti for illnesses to integrate
biomedical and traditional etiologies, manifestations, and treatments. Brodwin’s discussion of *eklanpsi* and Dornemann’s observation that *move san* can lead to diabetes and hypertension are two additional examples of this breakdown of medicinal boundaries.

Traditional healers in Haiti often acknowledge the limits of their practices and praise the unique benefits of biomedical treatment. One *oungan* interviewed in Lahoye explained, “You [*oungans]* combat the spirit and combat the *zonbi* [supernatural method of controlling another’s body and actions], but the natural illness part, it’s not for you. That makes you obliged to send the person to see the doctor” (Khoury, 2012). A *doktè fèy* echoed this sentiment in a different report, noting “I have medicine, which cleans and purifies the blood. I treat children who aren’t growing well, or who are being persecuted by evil spirits. In addition, we always make sure that the sick person gets the best possible care from a medical doctor, and sometimes the doctor works with me. I work with people who have chronic illnesses, includes diabetes, hypertension, and HIV/AIDS. While I cannot cure these diseases, there is much that can be done to help a person live a longer, healthier life.” (Nicolas, 2010)

Both of these accounts demonstrate the respect that many Vodou healers have for biomedicine. In addition, they point to a strength of Vodou medicine: its ability to ease quality of life and address social and moral factors that may not factor into the clinical dialogue. (Maternowska, 2006). In the case of the woman suffering from *pa-pale* in Karen McCarthy Brown’s case study, the mambo responsible for her treatment took her into her home, fed and clothed her, and held her at night until
she was able to speak again. Meanwhile, many medical doctors in Haiti, despite providing excellent care, dismiss supernatural concerns and reproductive illness accounts as trivial, delusional, or a sign of lack of proper education (Maternowska, 2006)(Singer, 1988). They may treat physical symptoms but neglect to address external factors that contribute to these symptoms.

A class of practitioners in Haiti attempts to capitalize on these alternative strengths by combining biomedical training with traditional herbalist treatment. Although uncommon, these care providers, also called *doktè fèy*, are licensed nurses and technicians who relocate to rural areas and utilize both stethoscopes and teas in their practices. (Vonarx, 2011). These “docteurs des deux mains,” “doktè de men,” or “doctors on both sides,” may aid in supplementing biomedical treatment with an appreciation for Vodou conceptions of illness.

Haitian medicine represents a unique brand of medical pluralism. A combination of state-run institutions, non-governmental organizations, and several categories of traditional healers work in tandem to provide care. In terms of maternal health, much of the care is provided locally by *fanm saj*, although recent government and donor initiatives seek to increase institutionalized reproductive care in order to combat maternal and infant mortality in Haiti. While these initiatives are making considerable progress towards improving birth outcomes, they run the risk of alienating patients by failing to take into account their spiritual well-being and day-to-day encounters with issues of poverty, abuse, and gender inequalities. Rather than viewing traditional medicine as an “obstacle” to improving health, physicians and MSPP officials should think critically about what can be
learned from these practices and how this knowledge can inform national health policies.
Chapter Four
Making Meaning of and Treating Reproductive Illness

Given what we know about reproductive illness accounts, social inequalities in Haiti and the complex medical system that diagnoses and treats health problems, how do we make meaning of reproductive illnesses? How do we explain them in a way that broadly encompasses many factors that shape them but does not explain away real physical symptoms as merely psychological or reduce them to biomedical concepts disguised by Creole idioms? Furthermore, how do we address the public health consequences they impose in order to inform treatments that are holistic and context-specific?

One fairly common approach to assessing culture-specific illnesses is to view conditions that have not been scientifically researched as purely psychological problems, which can then be mapped onto existing Western psychiatric concepts (Farmer, 1988)(Watters, 2010). What follows from this is that any physical symptoms are mere products of somatization, or physical manifestations of psychiatric disorders. Freud described somatization as the subconscious channeling of repressed emotions into physical signs as a way to communicate psychological turmoil. If we apply this to various Haitian reproductive illnesses, we can start to make assumptions based on DSM criteria. For instance, move san might really be Generalized Anxiety Disorder, because in instances of both, women report loss of appetite and headaches. Similarly, pa-pale might really be a psychotic break,
Pèdisyon may really be a coping mechanism for loss of fertility, and matris deplase may just be post-partum depression.

This type of thinking is problematic in three ways. First, it assumes that Western psychiatry is a stable framework. The writers of the Diagnostic Statistical Manual (DSM), the diagnostic classification system used by mental health professionals in the U.S., will release its fifth edition later this year. The new volume includes dozens of changes in specific diagnostic criteria as well as the inclusion of new disorders and exclusion of previously recognized disorders.

All of these classifications are based on self-report symptoms and psychiatrist observations and are thus highly subjective and variable among doctors. Since the criteria for labeling mental illness in the American medical system is an imperfect and highly subjective science, imposing these diagnoses on other cultures is a potentially dangerous practice.

Next, by reducing illnesses to psychological entities and depriving them of physical meaning, one reinforces a false Cartesian dichotomy between mental phenomena and physical symptoms. For instance, to say that move san is Generalized Anxiety Disorder, and that boutons, headaches, loss of appetite, and impaired vision are mere artifacts of a mental problem is to underscore the complex biological effects of stressful life experiences, poverty, and discrimination. A growing body of research has linked prenatal stress to maternal and child health outcomes. Prenatal stress and maternal trauma have been found to mediate a number of biological effects, including increased cortisol levels, weakened immune response, preterm birth, low birth weight in children, and respiratory illness and
asthma in children (Austin, 2005)(Sternthal, 2009)(Wadhwa, 2005). A recent study by the National Institutes of Health found that pregnant women who experience stress in the year before giving birth are more likely to give birth to stillborn babies; the stressful event most highly correlated with this outcome was interpersonal conflict (Belluck, 2013). Although the biological pathways that link these multiple effects are not precisely understood, there is irrefutable evidence that psychological disorders are not confined to neural circuitry; no mental illness is truly “all in one’s head.” There are very real consequences of the reproductive illnesses documented in this paper. A woman afflicted with pa-pale or who is indispose cannot care for herself or her children. A woman with lèt gate can induce diarrhea in her child by breastfeeding and increase her child’s risk of subsequent infection when she stops breastfeeding. Instead of questioning the legitimacy of reported symptoms –i.e. is the breast milk really spoiled?-- the conversation should focus on the profound effects of stress on reproductive biology and how these illnesses are representative of this relationship.

Finally, the most compelling reason to question psychological reductionism and somatization is that they are vast oversimplifications of complex problems. While we cannot help but see Haitian reproductive illnesses through our own shaped sense of reality- a reality which equates medicine with biomedicine- we can think critically about the context that makes the expression of these illnesses so unique. By “context,” I mean historical, political, social, and cultural considerations that produce vulnerabilities and adverse health outcomes. During Paul Farmer’s documentation of move san in Do Kay, he encountered one woman in her late sixties,
Madame Gracia, who linked the 77% lifetime prevalence rate of move san with difficult living conditions brought on by the recently constructed Péligre Dam. She states, “Move san is not something that was regularly seen before [the valley was flooded]. Some people died from it after the dam was finished. Now we are up here and we are poor. We have no livestock, no [sugarcane] mills. We suffer too many shocks (sezisman), too many problems. We are poor and we are weak, and that is why you see move san.” (Farmer, 1988). Madame Gracia points to poverty as one of the forces that can increase vulnerability to move san. Similarly, Dr. Chakhtouri observed that several women she interviewed in Léogâne who did not have lèt gate before the earthquake suddenly developed the condition after January 12th, 2010. It is imperative to consider the context of each woman’s life in broader historical patterns of poverty, gender inequality, gender violence, health infrastructure and medical pluralism to understand the full weight of a reproductive condition.

It is useful to consider anthropologist Margaret Lock’s notion of “local biologies” to explain cultural health differences. Margaret Lock conducted research on menopause among middle-aged women in Japan, the United States, and Canada. She discovered that while women in the United States and Canada commonly experience hot flashes or hot flushes, this description is rarely reported in Japan. Most Japanese women associate the cessation of menstruation with kônenki, a condition characterized by stiff shoulders, tingling sensations, and headaches (Lock, 2001). Lock argues that one cannot simply equate menopause and kônenki. Instead, they should be accepted as different disorders; additionally, they are indicative of the fact that there are biological differences between Japanese and American bodies,
shaped by unique cultural and historical forces such as diet. Thus, illness is transformed into “embodied experience” (Lock, 2001).

The concept of local biologies is hardly a novel concept in literature on Haiti. In the 1700s, many doctors believed that the tropical climate changed the bodies of slaves and white settlers in Saint-Domingue. Among women, this transformation led to poorly regulated periods, early menopause, and an enhanced ability to withstand pains of childbirth (Weaver, 2005). While these claims have not been widely echoed or verified, the observations represent an appreciation for contextual factors that shape health outcomes. Under the umbrella of reproductive illnesses in Haiti, embodied experience is evident in many descriptions. For the women of Do Kay, move san can be explained as embodied poverty. For countless other case studies, reproductive illnesses are embodied gender violence, embodied caretaking burdens, embodied financial insecurity, embodied birthing difficulties, and the embodied experience of layered trauma. This framework can inform holistic treatments that alleviate suffering while addressing root causes of illness expression.

While I caution against the practice of psychiatric mapping, I do not wish to dismiss its utility entirely. It can be useful to acknowledge recurring patterns of idioms of distress and symptoms in order to alleviate suffering for as many women as possible. For example, Dr. Guerda Nicolas, a Haitian-born psychologist, used clinical observations among Haitian immigrant women to categorize expression of culturally recognizable depressive symptoms. Her research found that women discuss three distinct types of depression: douleur de corps, or frequent pains and gas in the body, soulagement par Dieu, or a reliance on God to cope with negative
emotions, and *lute sans victoire*, or a feeling of resignation towards life and hopelessness in the future (Nicolas 2007). These idioms share many characteristics with depressive disorders, but the point here is not to box the three designations into a DSM diagnosis. Instead, understanding that these conditions are prevalent among female Haitian immigrants can help professionals to provide informed health and mental health treatment options.

Finally, if we dismiss the American psychiatric framework entirely as a reference point for Haitian reproductive illnesses, we may be ignoring potential treatment options that could alleviate suffering. Currently, mental health infrastructure in Haiti is limited; a 2003 World Health Organization report estimated that there were only 10 psychiatrists and 9 psychiatric nurses working in the public sector that year (WHO, 2010). To assume that mental health services would not be useful for treating reproductive illnesses simply because they are not a current treatment option is analogous to assuming that the majority of Haitian women deliver at home as opposed to in hospitals because they prefer to, when in reality they usually lack the choice.

As described in Chapter 3, traditional medicine and biomedicine are not mutually exclusive. Offering mental health services throughout Haiti would not underscore the importance of Vodou healers and herbal remedies in treating ailments. It would, instead, empower women with the choice to seek one or multiple treatment options. It will be essential going forward to gauge Haitians’ perspectives on the efficacy of mental health treatments such as cognitive
behavioral therapy in treating reproductive illnesses to understand if they are useful options.

An ideal approach to reproductive health in Haiti would be a prenatal and obstetric care regimen that a) examines the root causes of patient health complaints, b) does not marginalize these complaints, and c) offers comprehensive treatment options through integration of traditional healers and psychologists in order to alleviate reproductive illness symptoms and provide both clinical expertise and social support. Case studies of reproductive illnesses can enhance this approach by providing an anthropological “translational science” in which individual stories can inform health policy and improve medicine.
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