

Children Are the Wealth of the Poor: Prevention of Mother-to-Child Transmission of
HIV in Haiti

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Abstract

At roughly two percent, Haiti has one of the highest HIV prevalence rates in the Caribbean. This thesis examines HIV transmission in Haiti, specifically the transmission of HIV from mother to child during pregnancy, labor, and breastfeeding. Though the World Health Organization and other multilateral institutions have developed a protocol for prevention of mother-to-child transmission for those living in poverty, their recommendations fall short when faced with the reality of childbirth in rural Haiti. This work explores the class and gender disparities that put poor Haitian women at risk of contracting HIV. It also describes the social factors and international power dynamics that keep Haitians in poverty and make them vulnerable to HIV transmission. Furthermore, an examination of the current model of humanitarian assistance in Haiti shows that the existing system of aid does little to help poor mothers avoid passing HIV to their children.

Table of Contents

Acronyms and Abbreviations.....	v
Preface.....	vi
Introduction.....	1
Haiti and HIV.....	2
A Note on Statistics and Methodology.....	5
Chapter 1 – Class and Family Structure.....	6
Class Structure.....	6
Family Structure.....	10
Chapter 2 – Pregnancy and HIV.....	21
Maternal Health Care.....	26
Mother-to-Child Transmission of HIV.....	29
Children with HIV.....	32
Chapter 3 – The Future of PMTCT in Haiti.....	36
Poverty in Haiti.....	37
Infrastructure in Haiti.....	40
International Aid for the 2010 Earthquake.....	44
The Problem with Food Aid.....	49
Problems with Aid Agency Operations.....	53
Corruption and Foreign Aid.....	54
Capacity Building.....	61
Conclusion.....	64
Bibliography.....	69

Acronyms and Abbreviations

- AIDS** – Acquired Immunodeficiency Syndrome
- AMDD** – Averting Maternal Death and Disability
- ARV** - Antiretroviral
- AZT** – Azidothymidine, a type of antiretroviral medication
- CIA** – Central Intelligence Agency
- EBF** – Exclusive Breastfeeding
- GPRSP** – Growth and Poverty Reduction Strategy Paper
- HIV** – Human Immunodeficiency Virus
- IMF** – International Monetary Fund
- MSPP** - Ministère de la Santé Publique et de la Population, or Ministry of Public Health and Population
- NGO** – Nongovernmental Organization
- NPR** – National Public Radio
- PAHO** – Pan American Health Organization
- PEPFAR** – President’s Emergency Plan for AIDS Relief
- PMTCT** – Prevention of Mother-to-Child Transmission
- UNAIDS** – Joint United Nations Program on HIV/AIDS
- UNICEF** - United Nations Children’s Fund
- USAID** – United States Agency for International Development
- WHO** – World Health Organization

Preface

In my own travels to Haiti, I met a young girl who I will call Marie, to protect her privacy. Marie was thirteen at the time of the January 2010 earthquake. She was in Port-au-Prince during the quake because her parents sent her from her rural village to live with a family in the capital, a process known as restavek. Under the restavek system, children are sent to live with other family members or friends, with the understanding that the extended family will care for the child and send him or her to school, in exchange for the child's help around the house. In Marie's case, as in many others, she became an indentured servant in her new home.

On her way to collect water one day, Marie was assaulted by several men, who gang-raped her. Marie was too ashamed and scared to tell anyone what had happened, but when her guardians discovered that she was pregnant, they threw her out of their home. Marie was homeless, wandering the streets of Port-au-Prince when the earthquake struck. She was discovered by a pastor who was affiliated with an international charity and brought to the orphanage where I met her. Marie gave birth to her daughter just a few days after she arrived at the orphanage. She most likely received no prenatal care. She has not had contact with her family since she was thrown out of her guardians' home. Marie and her daughter are still living at the orphanage. Marie's traumatic experience has made her extremely withdrawn. She left her daughter's care to others at the orphanage for the first year of her life and it is only recently that she has begun to connect with her.

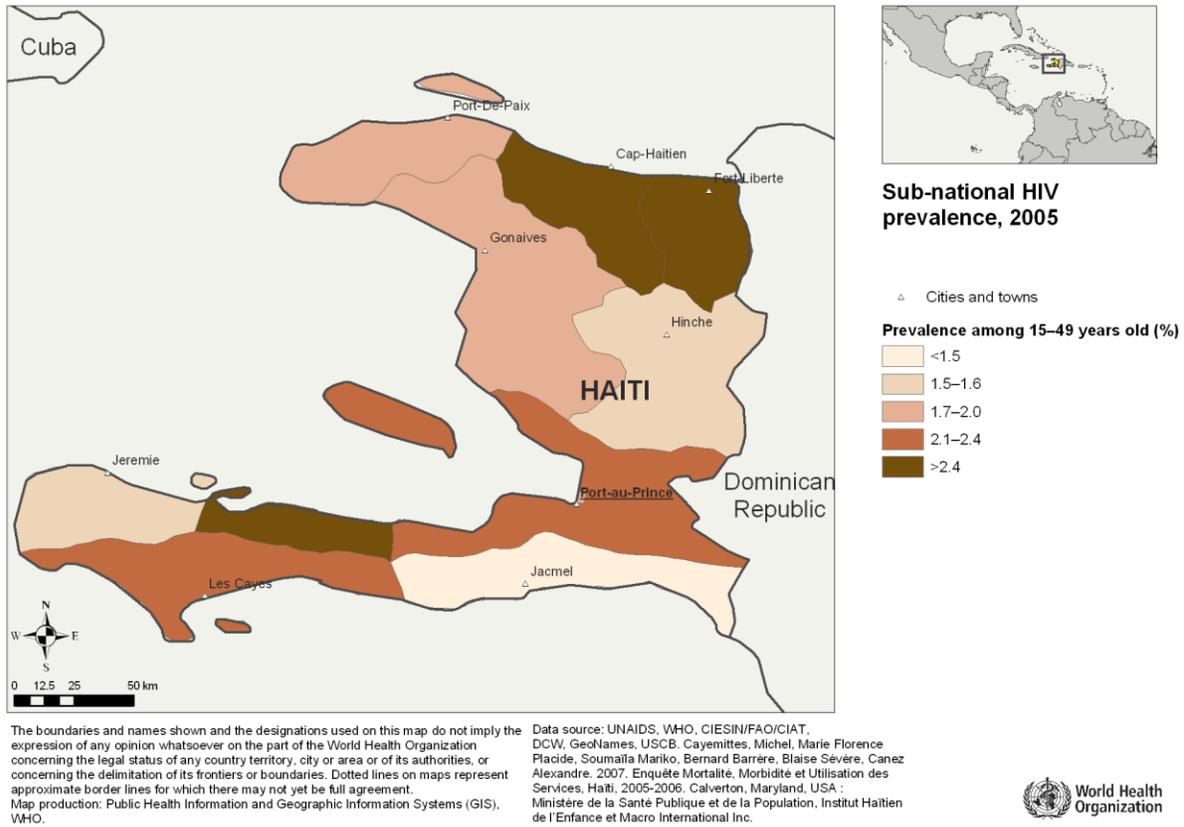
Marie's daughter is now a beautiful toddler who is a joy to all those around her. But the circumstances of her birth are a testament to the dire social conditions that shape the lives of the Haitian poor. Marie was sent to live with strangers because her parents could not afford to raise her in their rural village. She was turned into a servant because her guardians knew her parents could not stop them. Marie's attackers were never caught because Marie was too ashamed to go to the authorities. Even if she had made a report, it is unlikely that the police would have taken the word of a poor young girl over several adult men. Finally, the way that Marie's guardians threw her out on the street is indicative of the disposable nature of the poor in the minds of the rich. I could not bring myself to ask if Marie and her daughter had been tested for HIV. If they are HIV positive, their lives will be a struggle when it is time for them to leave the orphanage.

Introduction

“Children are the wealth of the poor” is a common proverb in Haiti. In a country where over 70 percent of the rural population lives in abject poverty (CIA Factbook 2011), children are one of the few assets people can claim, yet the barriers to raising a healthy family in Haiti are seemingly limitless. Decades of political instability, a crippled infrastructure, and environmental degradation have left Haitian families with little hope for the future. Amidst these conditions, the introduction of HIV has been devastating. Haitian mothers who are HIV positive are struggling to avoid passing a life-long illness to their children through pregnancy and nursing. The medical advances that protect virtually every child in the developed world from contracting HIV are out of reach for the average Haitian mother (WHO 2010). Specifically, the prevention of mother-to-child transmission of HIV, known as PMTCT, is limited to those who can afford it. In the following chapters, I argue that, in Haiti, social factors and international power dynamics are more important determinants of HIV transmission than medical factors. Furthermore, through an examination of the current model of humanitarian aid in Haiti, I contend that the existing system of aid does little to help poor mothers avoid passing HIV to their children.

HIV/AIDS has been in the public consciousness for decades. Though there is still no cure, there are effective ways to stop the spread and protect oneself from contracting it. But for some of the most vulnerable people in the world – poor, Haitian mothers – the resources and education needed to protect themselves are restricted. A combination of social, economic, and political factors, which I describe in the following chapters, often force these women into situations in which they risk exposure to HIV. However, even if these women do become infected with HIV, medication and breastfeeding techniques can help them avoid passing the infection on to their children. The question of whether or not these resources are readily

accessible to the women who need them is one that I hope to answer in the following pages. A child born to a rural woman in Haiti, the poorest country in the Western Hemisphere, will already face a difficult life. Preventing the additional burden of HIV is a small step to give that child a better chance at a healthy life.



Haiti and HIV

Haiti’s role in the HIV epidemic is unique. At roughly two percent, Haiti has one of the highest HIV prevalence rates in the Caribbean, second only to the Bahamas (UNAIDS 2010). The first diagnosed case of HIV in Haiti was in the early 1980s, at the same time the disease was being discovered in the U.S. When several Haitian immigrants were diagnosed with Kaposi’s Sarcoma, Haitians were added to the “Four-H Club” – homosexuals, heroin users, hemophiliacs and Haitians – those people considered to be at high risk for HIV. Panic spread and discrimination against Haitians in the United States reached new levels. Haitian immigrants lost

their jobs and were evicted from their homes because of their perceived association with HIV (Avert.org 2010). Haitian refugees attempting to enter the United States were forcibly tested for HIV and those found to be positive were quarantined at Guantanamo Bay in barbaric conditions. The country's tourism industry was effectively destroyed within a year of reports that HIV came from Haiti (Farmer 1994). Even after decades of AIDS activism and raising awareness, Haiti cannot shake the stigma of being associated with HIV, a fact that manifests itself in Haiti-U.S. relations.

The relationship between Haiti and the United States is extraordinarily complex. There is a widespread belief among Haitians that the United States controls Haitian politics and exploits the country for its resources (Farmer 1994). Some critics have labeled this as paranoia, although an analysis of history shows this perception has basis in fact. Given the contentious history between the Haiti and the U.S., Haitians were not surprised when they were blamed by the U.S. for spreading HIV. Many assumed that this was just another example of the discrimination faced by Haitians since the country's founding in 1804. However, recent epidemiological analysis challenges this view. In October 2007, Dr. Michael Worobey and colleagues released a study that stated, with 99 percent certainty, that HIV subtype B developed in Haiti sometime between 1969 and 1972 before spreading to the United States (Avert.org 2010). At this time, many Haitians were returning from contractual work in Congo, where HIV is believed to have originated. According to Worobey's analysis, the virus most likely passed from person to person on the island before being transmitted to the U.S. The study took care to point out that this was only one of the possible ways the virus could have entered the United States. In fact, several cases of what was later found to be HIV had already been reported in the U.S. (Avert.org 2010).

By the time Worobey's study was released in 2007, the damage caused by the suspicion that HIV came from Haiti had already been done.

HIV/AIDS is widely stigmatized in Haiti. The most common way HIV is spread in Haiti is through heterosexual contact. Despite this fact, HIV is still associated with homosexuality, which is also highly stigmatized. HIV spread quickly in the capital city of Port-au-Prince, but it took several years for the virus to reach the rural areas. Ethnographic studies in rural Haiti suggest that rural villagers associated the disease with urban lifestyles, homosexuals, constant diarrhea and tuberculosis (Farmer 1990; Walton 2004). Voodoo also shaped perceptions of HIV. According to traditional Voodoo practice, illness can be caused by biological means (microbes, bacteria, etc.) or it can be sent by one's enemies. "Sending sickness" and "expedition of the dead" was cited constantly as a cause for illness in rural villages (Farmer 1990). This was especially true when HIV first appeared in these villages. As people became more familiar with the disease, they acknowledged that HIV could be spread through sex with an infected person, which causes *move san* (bad blood). They also believed that HIV could be sent by someone's enemies. If HIV was contracted biologically, it would respond to treatment. If it was sent, it could only be cured by a houngan, or Voodoo priest (Farmer 1990). Those attempting to prevent and treat HIV without acknowledging the complex social, historical, and religious environments in which the disease is spreading will have little chance of success.

In the following chapters, I examine HIV in the context of Haiti. In Chapter 1, I analyze Haitian class structure and the disparities that allow the wealthy elite to remain in power, while the poor majority struggle for daily survival. I then turn to the Haitian family to show how deeply-rooted conceptions of gender, in combination with political and economic forces, create inequalities of power between men and women. In Chapter 2, I contrast PMTCT

recommendations of multilateral institutions like the World Health Organization with the reality of childbirth in rural Haiti. I also discuss the difficulty of raising a child with a chronic illness like HIV while living in poverty. In Chapter 3, I describe Haiti's infrastructure and the problem it poses for the rural poor. I also focus on the role of humanitarian aid in Haiti and the country's place within the international power structure. I conclude by discussing areas for future research in prevention of mother-to-child transmission of HIV.

A Note on Statistics and Methodology

The following pages contain numerous statistics about rates of HIV infection, living conditions in Haiti, and effectiveness of medication. These numbers are compiled by national governments, multilateral institutions, and scholars. To the best of my knowledge, they are as accurate as possible. However, it is important to note here that international agencies repeatedly emphasize the difficulty of gathering reliable data. Stigma and lack of testing most likely suggest that HIV infection rates are much higher than officially stated (UNAIDS 2010). Many of the topics discussed here are sensitive and deeply personal to the people involved. For every person that came forward to discuss these issues, many more may have been reluctant. Furthermore, the way data is presented is inevitably influenced by the authors' own biases, shortcomings, and agendas (my own included). The decision to include some pieces of information and exclude others for the purposes of conciseness, credibility, and perceived relevance means that all analyses are inherently flawed. Finally, I must acknowledge that the impact of losing of one mother, one father, one child can never be conveyed in a single statistic. That said, I hope that this work will inspire others to think about the most effective way to stop the spread of HIV, for the sake of mothers like Marie.

Chapter 1 – Class & Family Structure

Class and family structure significantly impact the utilization of health services in Haiti. A highly-educated, upper-class Haitian woman has a vastly different experience during pregnancy than a poor, rural woman. Ethnographic studies of under-developed healthcare infrastructure reveal that the poor do not receive the same access or quality of health care as the wealthy (Briggs and Mantini-Briggs 2004; Farmer 2005; Biehl 2007). This is certainly the case in Haiti and the combined impact of gender inequality and poverty can be devastating for Haitian women in their struggle against HIV.

In this chapter, I analyze the Haitian class structure in order to show that the wealthy elite and the poor majority lead completely different lives. I then explain how disparate access to education and opportunities allow the wealthy to remain in power, while the poor struggle for daily survival. Finally, in examining the structure of the Haitian family, I describe the deeply-rooted traditions which, in addition to global political and economic forces, create inequalities of power between men and women.

Class Structure

One's place in Haitian society has traditionally been defined along racial and ethnic lines. White Frenchmen and their African slaves were the only people left on the island of Hispaniola after the indigenous population was completely eradicated by violence and disease brought by European settlers in the early 16th century. As a result, a three-tiered social structure developed, in which white Europeans held the highest class position in society, followed by the affranchis, a race of mulattoes descended from freed slaves. Black slaves held the lowest class in society. After the revolution in 1804, when the majority of Europeans left Haiti, the affranchis became the elite class. As of the 1980s, the elite made up less than 5 percent of the population, yet they

controlled over 90 percent of the country's wealth (Library of Congress 2006). The elite are highly-educated and speak French, rather than Haitian Creole (Leyburn 2004). Catholicism has been the dominant religion in Haiti since colonial times, although Protestant churches have gained a significant foothold since the 1950s. Historically, light skin has been an indicator of higher class, though Haitians of darker skin now make up a portion of the small elite class (Wucker 2000). By preserving French as the official language and Catholicism as the official religion, the Haitian elite have maintained their ties to France, thereby effectively isolating the majority of poor Haitians from civil society and international dealings.

The elite's place in society is firmly entrenched. They live in a self-contained suburb of Port-au-Prince called Petionville. At one time, this neighborhood contained the highest density of millionaires in the Caribbean (Bentivegna 1991, 5). Many of the elite own export businesses and come from generations of wealth (Davidson, Joffe-Walt, and Glass 2010). Haiti's early leaders struggled to establish an economy and, in their desperation, they agreed to unbalanced trade agreements with the United States and several European countries. A feudal system developed within Haiti, not unlike the slavery during French colonialism, in which the rich upper class exploited the poor peasantry to satisfy international trade demands (Farmer 1994). As shown in Chapter 3, international trade relations are still unbalanced, putting Haiti at a disadvantage to the United States and Europe (Wilentz 2010). In order to fulfill the expectations of these developed countries, a version of the post-colonial feudal system persists to this day between the Haitian elite and the poor.

Elite families often send their children abroad to attend university and frequently travel to the United States and Europe. This is indicative of exceptional treatment afforded to Haitian elite by rich nations, as an average, poor Haitian has virtually no chance at being admitted into these

countries legally. The elite are highly-educated and politically well-connected and they often play a powerful role in the country's politics, particularly those policies that affect their businesses and personal wealth. Many scholars in the fields of politics and anthropology, as well as international human rights groups and journalists have accused the Haitian elite of orchestrating the 1991 coup that brought down President Aristide, a long-time advocate for the nation's poor (Farmer 1994; James 2010; Maternowska 2006; Wilentz 2010). Though some members of the elite class may pay gracious lip-service to the humanitarian and development efforts of foreigners (Bentivegna 1991; Schwartz 2010), as a social class, their primary concern has been to maintain the current status quo. Anecdotal accounts from aid workers, scholars and journalists tell of meeting with members of the elite in their lavish homes in Port-au-Prince where their concerns about the poor are dismissed as a thing of the past (Schwartz 2010). In other instances, the foreigners are thanked for their efforts, but told that the poor simply cannot be helped or that they deserve their fate (Kaufmann 2010). The elite make a conscious effort to distance themselves from the lower class of the Haitian poor (Farmer 2005). In doing so, they also distance themselves from responsibility for the plight of their fellow Haitians.

Religion is an important distinction between the poor and elite in Haiti. During colonialism, the Creole language developed among the slaves, as did the rituals of Voodoo. According the French Code Noir, rules that outlined the treatment of slaves, masters were required to indoctrinate their slaves with the teachings of the Catholic Church (Wucker 2000). Voodoo developed among the slaves as a form of resistance to this indoctrination, as well as a way that African slaves attempted to maintain ties to their heritage. While the Haitian elite publicly scorn Voodoo as a superstitious practice of the poor, uneducated masses, a common joke in Haiti refers to the country as 90 percent Catholic, but 100 percent Voodoo (Leyburn

2004), indicating that the elite may not be as far removed from Voodoo as their public images would lead one to believe. Rather than employing religion as a way to unite Haitians, the elite further divide themselves from the poor in public, despite their potentially similar religious practices in private.

The Haitian poor make up the vast majority of the population. In a country of almost ten million people, over 90 percent are considered lower class (Farmer 2005; CIA Factbook 2011). The Haitian poor typically have darker skin and little or no formal education. The majority of Haitian children lack access to quality education. As of 2008, less than half of Haiti's school-age children were enrolled in school (Wolff 2008, 3-4). At 53 percent, Haiti has the lowest average literacy rate in the Western Hemisphere (Library of Congress 2006). Women are generally less educated than men. On average, girls spend two years and eight months in school compared to a national average of three years and nine months (GPRSP 2007, 22).

Education Quality Indicators, 2006 (estimated)

<u>Percentage of over-aged primary students</u>	<u>72%</u>
<u>Literacy rate for population aged 13+</u>	<u>43%</u>
<u>Percentage of over-aged secondary students</u>	<u>78%</u>
<u>Estimated primary completion rate</u>	<u>67%</u>
<u>Percent of primary school teachers with training</u>	<u>20%</u>
<u>Percentage pass rate in 6th grade</u>	<u>66%</u>
<u>Student-teacher ratio, primary level</u>	<u>46:1</u>
<u>Percentage pass rate in 9th grade</u>	<u>57%</u>
<u>Length of school year</u>	<u>142 to 185 days</u>

Source: MENFP 2007, World Bank 2007 (Wolff 2008: 3)

Disparities in education are especially critical in the rural areas, where no schools exist within a reasonable distance for many families. Though the 1987 Haitian Constitution mandates free public education, many families cannot afford the supplemental fees, school supplies, and uniforms required, in addition to possible transportation costs. The quality of public education is extremely low and the majority of children who do attend school are enrolled in private schools, which the average Haitian cannot afford (Sorgen 2009). While Haitian parents do want their

children to have an education, poor parents often have no education themselves. Though they may value their children's education, they do not play an active role, tending to defer to schoolteachers (Center for Applied Linguistics 2004). Haitian children leave school for a variety of reasons, but the most prevalent one is poverty and the necessity of child labor. UNICEF estimates that as many as three hundred thousand Haitian children are involved in domestic labor in some way (UNICEF 2006, 2). While parents may decide that it is more important for a child to work for the family than attend school, it is extremely difficult for Haitian children to complete their education and acquire the skills needed for professional careers. Without an education, the poor are vulnerable to exploitation by authorities and the Haitian elite, and have fewer opportunities to influence the systemic inequalities that keep them in poverty.

The Haitian poor have traditionally relied on subsistence farming to earn a living, yet farm production has steadily declined to such an extent that many families can no longer support themselves (Farmer 1994). The lack of sustainable farming life has created a massive migration of people from the rural areas to the cities in search of work, but they often cannot find anything but temporary labor jobs. The immediate area surrounding Port-au-Prince is filled with slums and settlements of people who come to the city to make a better life, only to find themselves barely surviving on the wages they earn from manual labor jobs (Maternowska 2006). As examined in Chapter 3, this rural-to-urban migration has had a dramatic impact on both the transmission of HIV and family life in Haiti.

Family Structure

One's family is a source of pride in Haiti. Families spend a substantial amount of time together and rely on one another for love, support, and survival. Though family bonds are strong in Haiti, inequalities exist between men and women within the family. One's position in the

family can determine agency and this is particularly true with regards to health care, as I will explain later in this chapter. Gender roles are strictly defined in Haiti, especially among the poor, and institutions such as the Church and the State reinforce these roles through religious teachings and discriminatory laws (Maternowska 2006). Men and women perform their prescribed roles and duties. From the time they are young, Haitian girls and boys learn what is expected of them and, as they grow, they rarely diverge from these norms, for fear of social ridicule or isolation. This is especially true in the case of intimate relationships and family duties.

Among the elite, marriages take place for status as well as romance. Following French custom, weddings are formal and legally-binding. Elite couples tend to limit the number of children they have, which further distinguishes them from the Haitian poor (Leyburn 2004). Men dominate the political and business sectors and their spouses often choose not to work. However, elite Haitian women are well-educated and, in recent decades, they have entered the workforce in professions traditionally dominated by men, such as law and medicine. According to government figures, women represent 43.9 percent of persons in intellectual and scientific professions (GPRSP 2007, 22). Given the disparate access to education mentioned above, these positions are almost certainly filled exclusively by women of the elite class. Regardless of whether or not an elite woman works outside the home, many hire domestic servants and nannies to care for the children and the household. Today, scholars and journalists note that wealthy Haitian women have gained more equality with men (Schwartz 2010), but it is important to emphasize here that the situation for poor, black Haitian women has not followed a similar path. In fact, the status of poor, black women has not changed much from colonial times.

Outside of the elite class, formal, legally-binding marriage does not have a strong history in Haiti. In colonial times, slave owners discouraged weddings between slaves. They divided

families to avoid the possibility of insurrections and emotional ties. Masters often sold the children of their slaves as soon as the children could be separated from their mothers. Although some owners allowed couples to cohabit, legal and religious weddings were rare among slaves, in part to prevent large gatherings of slaves (Wucker 2000). Masters regularly had sexual encounters with their slave women. Though slaves formed bonds and valued traditional family life, the constant exploitation of slave women weakened any aspiration among slaves to formal marriage and monogamy (Leyburn 2004). Couples may have tried to keep their relationships secret to avoid showing any weakness. After the revolution of 1804, former slaves continued this tradition of informal unions.

The common informal unions among the Haitian poor are known as *plaçage*. Like common-law marriage, *plaçage* is quite open and carries no stigma or assumption of legal obligation for either party. The peasant class remains largely indifferent to formal weddings for several reasons. They see no need to disturb daily life and take time away from work for a wedding, and an expensive ceremony may invite jealousy from others. Moreover, the poor are also reluctant to legalize their marriages and interact with government officials, as endemic corruption and abuse of power are rampant among Haitian authorities. Finally, if the state and the Church attempt to limit a man to one wife, this would go against the well-documented cultural norm of poor Haitian life (Leyburn 2004). The alternative tradition of unofficial marriages has led to a deeply-rooted system of gender roles.

Differences in gender roles are most apparent in the household. Though elite women may choose not to work, poor Haitian women are expected to bring income to the family. Whereas an elite woman would never do housework, poor women cook, make clothing, perform fieldwork, and do the washing. They go to the market to sell produce or crafts, and are often accompanied

by their young children. Poor women manage the household, which includes handling the money during their partner's absence (Leyburn 2004). Though Haitian women are responsible for the home, they do not control the family finances, particularly if a couple is not legally married, which puts them at a disadvantage to the men in the family.

In both urban and rural Haitian life, men are traditionally the financial providers and decision-makers in the household. Haitian boys learn that to be a man is to provide for a family. Men consider work an important part of their identity. A man's earning power makes him desirable to women. Over two-thirds of the country depends on the agricultural sector, mainly subsistence farming in the rural areas, although this is not profitable, as discussed earlier. Haiti's official unemployment rate is currently over forty percent, although underemployment is widespread (CIA Factbook 2011). Most men rely on temporary work, especially in the urban areas. These are physically-demanding jobs, made particularly difficult by the fact that the men that do these types of jobs are usually malnourished. They don't have the strength to do strenuous labor, but they have no other way to earn money. This wears down their health, making it more difficult to work and buy food for their families, perpetuating this cycle (Maternowska 2006). If a man has several partners and multiple children, money is stretched more thinly, as the man is expected to support each household.

Haitian men often feel shamed and embarrassed by their inability to provide for their families. They sometimes turn to alcohol and sex as "distractions" to kill the time they aren't working. As I discuss in a following section on domestic violence, feelings of emasculation can result in domestic violence or forced sexual encounters. Outside observers have mislabeled the Haitian man as "lazy" and lacking ambition, but the fact is that there are simply not enough jobs for everyone (Maternowska 2006). Most jobs in Haiti are temporary, poorly-paid and physically

demanding. Most work occurs in the informal sector, as complicated and expensive regulations make it impractical for businesses to officially register with the government (Doing Business 2010). In the formal sector, the Haitian elite, as well as multilateral institutions like the IMF and the World Bank, have pressured Haitian authorities to keep the minimum wage extremely low and disband labor unions (Wilentz 2010). In both the formal and informal sectors, workers rights and government oversight are limited, putting laborers at a severe disadvantage to their employers.

In certain city slums, like Cité Soleil, men turn to crime to earn money. This is sometimes referred to as “working for the state,” a euphemism for participating in political gangs and organized violence, as shown in the documentary *Ghosts of Cité Soleil* (2007). For instance, gangs known as *chimères*, or ghosts, roamed the streets of Cité Soleil and other sections of Port-au-Prince, intimidating people into supporting the politicians who paid them or eliminating rival gang members (*Ghosts of Cité Soleil* 2007, Danticat 2008). Haiti is also a major hub for drug trafficking from South America to the U.S. In a particularly striking incident recounted in Dr. Timothy Schwartz’s book, *Travesty in Haiti* (2010), a small village benefited more in one day from a stolen package of cocaine than they did from years of humanitarian assistance. If people are very fortunate, they can rely on relatives living abroad to send them money. Remittances are the primary source of foreign exchange in the country (CIA World Factbook 2011). It is often joked that the missing Haitian middle class are the ex-patriots living abroad. With the limited opportunities afforded to the poor, one can see why some Haitian men believe that the only way to make money is through illicit activities or leaving the country.

While Haitian men may feel emasculated by their inability to provide financially, they also consider sexuality a central part of their identity. It is “who they are in a demeaning world”

(Maternowska 2006). There is strong social pressure to establish heterosexual partnerships as early as possible after puberty. A young man is considered strange if he does not overtly flirt with women and try to seduce them. Young women, meanwhile, search for a partner that will be able to bring income to the household, as well as physical security (Maternowska 2006). Women and men constantly negotiate for their own needs within the family.

To an observer more familiar with the Anglo-Saxon tradition of two-parent households, the family arrangements among the Haitian poor may seem callous, without regard for feeling or emotional connections. But, to Haitians, there is an element of romance to their courtships. During the courtship period, men buy small gifts for women to win them over, demonstrating the economy of romance. A common Haitian saying, “In order to have a woman, you must have money,” shows the importance women place on finding a man who can provide for them, as well as spoil them with gifts during their courtship, such as candy or clothing. Women make an effort to “look pretty in church” to catch the eye of attractive suitors. Some even employ Voodoo tactics make men fall in love with them (Maternowska 2006, 48-50). Men and women of similar social standing have more agency to choose a partner that suits them romantically, as well as economically.

Though both parties may enter into relationships with the understanding that the man will have relationships with other women, Haitians strive to be caring parents. In many societies, including Haiti, men say that having extra-marital sexual partners is not a reflection of dissatisfaction with their primary partners. Rather, as research has shown, structural and social factors are more important determinants of men’s infidelity (Hirsch 2009). In Haiti, having children is considered the final entry to adulthood. Haitian children are cherished and loved within the family. Even the poorest parents dream that their children will become doctors or

engineers. They want their children to be educated or to make it to the United States, the ultimate dream of many Haitians (Maternowska 2006; Danticat 2008). Children are also an investment for poor families. Haitian children are expected to help in the home. As young as age five, they carry water, run errands, and help with the washing. They look after younger children so their parents can work. At young ages, boys and girls perform “women’s work” – domestic duties like cooking and cleaning. Once boys reach adolescence, they are excused from these tasks, but girls are not (Maternowska 2006). When parents are too old to work, children are expected to care for them.

Women take pride in their ability to attract men, as well, but for many, this ability is more important for economic reasons. The pressures of raising a family and economic desperation often force poor Haitian women to use their sexuality strategically (James 2010). Women often find that they cannot support a household without economic help from a man. If a poor woman depends on a man for money, she has little room for negotiation and this is especially true when it comes to sex. The ability to bear children is women’s bargaining power in their relationships with men (Maternowska 2006). It is socially acceptable for men to have children with multiple partners, as a man’s virility is valued more than his fidelity to a single partner. This sort of polygamy is not considered the same as adultery. It is public and the goal is to have children. The man is supposed to be the financial provider for all the women and their children. Women are expected to be faithful to a single partner. However, many of these unions disintegrate after childbirth when the father cannot provide for his child (Maternowska 2006). As a result, women often have a different father for each of their children.

The family structure of a monogamous male-female relationship with children is particularly hard to maintain in the context of poverty in Haiti. For a woman to keep her male

partner close to the household, she often feels that she must give in to any of his demands, even if it poses a risk to her own safety (Kristof and WuDunn 2010). For example, condoms are stigmatized in Haiti (Avert.org 2010), as well as discouraged by the Catholic Church, the dominant religious institution in the country. Poor women do not have the power to insist that their partners use condoms, even if they are concerned about sexually-transmitted diseases or do not want to become pregnant. As one woman says about her relationship, “I ask him to use [condoms]; he says no. It’s not a small refusal; he’ll slap me when he’s angry. This is why [men] tell us that one single woman isn’t sufficient; if I don’t give, the other [woman] will.” (Maternowska 2006, 72) Other types of family planning, such as birth control pills or intra-uterine devices, are also looked down upon and considered unnatural. If a woman’s partner discovers her using contraceptives, she may be vulnerable to violence and humiliation, as this act would challenge her male partner’s authority and control over reproductive matters. Because of this, if women do choose to use family planning services, they may try to hide it (Maternowska 2006, 69-74). Poor Haitian women are often forced to set aside their own safety in attempts to hold their families together.

Domestic violence is assumed to be commonplace in Haiti. Although official statistics do not exist on the topic, a study done by a women’s advocacy group, Kay Famn, found that 40 percent of respondents reported experiencing domestic violence (Ravitz 2010). In another survey of several dozen women in Cité Soleil, every woman reported experiencing violence from a male partner (Maternowska 2006). These women reported that their partners would slap or beat them during arguments about money or for refusing sex. A few women recalled being beaten for not fulfilling their household duties – in one case, for cooking something that wasn’t “tasty” (Maternowska 2006, 62). These incidents are rarely reported to police, as poor women would

rather endure the beatings than go without a man's contribution to the household. The underreporting also reflects a general lack of trust in government authorities, a topic to be examined in Chapter 3.

Women often place certain expectations on themselves, such as the importance of becoming a mother. As discussed earlier in the chapter, children are valued in Haiti and having a child is considered an important rite of passage for a woman. It solidifies her place in society and may help to strengthen a relationship with a male partner. Women start having babies relatively young, around seventeen or eighteen (Maternowska 2006). The inability to bear children is a deeply damaging social stigma for a woman. The desire to have a child may outweigh a perceived threat of contracting a sexually-transmitted disease like HIV. Furthermore, Haitian women have expressed their reproductive behavior in terms of political motivation (Maternowska 2006; James 2010). When speaking in this way, poor Haitian women identify their ability to bear children as both a source of power in their personal relationships as well as a form of resistance against international power structures that keep them in poverty (James 2010; Singer, Davison, and Gerdes 1988). In one such conversation, when asked why she did not use available contraceptive resources provided by an international donor, a poor Haitian woman replied, "Because it enslaved me." (Maternowska 2006, 2). By bearing children, women enact their personal desire to raise a family, fulfill societal expectations, and express political resistance in one of the limited avenues available to them.

Outside of the family setting, women face additional hurdles to protect themselves from HIV and other sexually-transmitted diseases. During times of political upheaval, rape has been documented as a weapon of war. As Haiti has been in a state of almost constant political turmoil since its founding, there is some evidence that HIV has been transmitted through rape. In the

study mentioned above by Kay Fann, seventy-two percent of women reported being raped (Ravitz 2010). Sex coerced through violence increases the risk of microlesions, which increases the risk of transmission for HIV (Kristof and WuDunn 2010). Despite this vulnerability, in certain cases, a woman's body is her most valuable resource. This is reflected in slang references to the "land" between a woman's legs - a source of capital, capable of producing wealth. Women even refer to their own genitalia as "my goods" and "my country" (James 2008). Female sexuality is illustrated in songs and dances that children learn from an early age.

With this mindset, poor women may turn to prostitution to earn money. Prostitution is considered shameful and women do not make this decision lightly. Yet, in cases of extreme poverty, poor women may feel they have no choice, despite the risks involved (James 2008). These women consider themselves different from the professional sex workers such as those in Carrefour, a neighborhood in Port-au-Prince that was once a hot spot for sex tourism in the Caribbean. In the early 1980s, around the same time that HIV was beginning to spread around the world, American and European tourists came to Carrefour to seek out Haitian sex workers (Bentivegna 1991). The virus was most likely passed back and forth between Haitians and Americans, particularly through homosexual contact, which carries a very high transmission risk (Farmer 2006). In a larger sense, the fact of Americans and Europeans coming to Haiti to buy sex reinforces institutional prostitution and economic desperation. It further exemplifies Haiti's dependence on the U.S. and Stoler's concept of the sexualized Other, manifested in the way sex tourists eroticize differences of race and economic position (Brennan 2004). However, as methods of HIV transmission became more well-known, sex workers were heavily targeted in prevention efforts and encouraged to use condoms with their clients (IRIN News Service 2010).

Poor women who were trying to keep their prostitution secret did not benefit from these prevention efforts.

In Erica Caple James' study of trauma in Haiti (2008), she interviewed several women who were engaging in sex for money. These women reluctantly described their experiences "meeting men" in the dark of night, in isolated places, keeping their work secret from their families to avoid shame (James 2008). Men paying for sex often do not want to use condoms and will either pay more not to use one or go to a different prostitute. Under these conditions, it is hard for a woman to protect herself. Additionally, prostitutes are often vulnerable to violence and rape. Because of their illegal status, they are also subject to exploitation from the police or pimps (Kristof and WuDunn 2010). If a woman happens to become pregnant through prostitution, her economic situation becomes even more desperate, which may lead to even more dangerous behavior.

The inequalities described here, both between the elite and the poor, and within the family, place poor Haitian women in a perilous position. Though they retain a certain amount of agency, Haitian women's choices about healthcare and childrearing are severely constrained by poverty, social pressures, and international power dynamics. These conditions put women at a disadvantage even before they consider becoming mothers and raising families. In the next chapter, I explain the difficult conditions under which poor women give birth in rural Haiti and the added dangers women face when they are HIV positive.

Chapter 2: Pregnancy & HIV

In Dr. Paul Farmer's writings (1994, 2005), he often recalls the story of Acephie as foundational example of the structural violence that keeps Haitians impoverished. Acephie was born in Haiti's Central Plateau, a poor rural area whose residents have been displaced by an American-funded hydroelectric dam along the Riviere Artibonite. Her parents and ancestors made a modest living, farming the valley before it was flooded by the dam in 1956. They were driven from their homes up the rocky hillside, where the soil was too poor to farm, without compensation for their lost property. Acephie's father could only produce a small crop in the new location which her mother took to market to sell each week. The family grew increasingly impoverished. When Acephie was nineteen, she had to leave school to help her family earn money, although she had only reached primary school level. She traveled with her mother to help at the market each Friday. The trip took an hour and a half in each direction and, on the way, they passed a military barracks. The soldiers at the barracks would tease and flirt with the market women as they passed by, sometimes imposing arbitrary taxes before letting them continue. As the salaried soldiers were some of the few men in the area with a steady income, they were attractive matches for the poor peasant women. When Acephie caught the eye of one soldier, Honorat, she did not reject his advances, although it was widely known in the community that he had a wife, children, and several other girlfriends. When Honorat approached Acephie's parents about starting a relationship with her, they did not dissuade the couple. Acephie later wished they would have. She said, "What would you have me do? It was a way out, that's how I saw it."

The two were only sexual partners for a month before Honorat fell ill. He went home to stay with his wife and died a few months later. With little education and no prospects for financial security through a partner, Acephie felt she had no choice but to enroll in a "cooking

school,” a euphemism for a school that trained poor girls to be servants in the capital city. Acephie soon found a job as a maid for a middle-class Haitian woman working for the U.S. Embassy in Port-au-Prince. She worked for the woman for several years and began dating a young man, Blanco, who she knew from school. He, too, had a steady job as a bus chauffeur. They saved their money and planned to be married until Acephie became pregnant. Upon hearing this news, her employer fired her, as it is considered unsightly to have a pregnant servant. Blanco also disappeared. Acephie moved back to her hometown and the two saw each other only a few more times. He was not present for the birth of their daughter.

A few months after Acephie gave birth, she fell ill. She fought frequent infections, drenching night sweats, and constant diarrhea. Eventually, she was diagnosed with AIDS. Her care was frequently interrupted, as her local clinic was often closed due to political violence in the area. Some people in the village believed that Acephie was the victim of sorcery. Others recalled her relationship with Honorat and the years she had spent in the city, both of which the rural villagers associated with HIV. Acephie died before she had chance to care for her daughter, who was also infected with HIV. Currently, Acephie’s family is caring for her daughter, but without treatment and a change in her economic situation, her life may not be much different from her mother’s.

Acephie’s story serves as an example of the hardships poor Haitian women must endure. Her tragic struggles in life and her ultimate death from AIDS-related illness are the result of systematic inequalities that exist in Haiti and in poor countries around the world. Although Acephie’s story is heartbreaking, it is not unique. Like many poor people, she did not have enough education to secure a good job. Like many poor women, she entered into a relationship for economic, as well as romantic reasons. Finally, like most poor, Haitian women, Acephie gave

birth at home. All of these factors contributed to Acephe passing HIV to her daughter (Farmer 2005), a fate that awaits more Haitian children if more is not done to prevent it.

Poor Haitian mothers struggle to raise healthy children under the best circumstances. The additional burden of raising a child with a chronic illness, such as HIV, can be overwhelming. In this chapter, I explore the World Health Organization (WHO) recommendations for prevention of mother-to-child HIV transmission (PMTCT) in resource-poor settings and how these recommendations are being implemented in everyday life in Haiti. An examination of PMTCT services in countries similar to Haiti shows that family and societal expectations often conflict with and override medical advice. Furthermore, studies of maternal health services in rural Haiti show that infrastructure and economic factors have more influence on the use of services than a woman's desire to seek medical treatment. Finally, an examination of Haitian birthing practices illustrates the difficulty in implementing PMTCT services, including the nationwide shortage of health resources and the fact that most women give birth at home. The chapter will also briefly examine the challenges of raising a child with HIV in the context of poverty. The combined impact of all these factors creates a difficult situation for Haitian mothers.

**Table 3: NUMBER OF PLHIV AND ADULT HIV PREVALENCE BY COUNTRY.
UNAIDS/WHO.2010**

COUNTRY	NO OF PLHIV IN 2009	ADULT HIV PREVALENCE IN 2009
The Bahamas	6,600 (2,600-11,000)	3.1% (1.2-5.4)
Barbados	2,100 (1,800-2,500)	1.4% (1.2-1.6)
Belize	4,880 (4,000-5,700)	2.3% (2.0-2.8)
Cuba	7,100 (5,700-8,900)	0.1% (<0.1-0.1)
The Dominican Republic	57,000 (49,000-66,000)	0.9% (0.7-1.0)
Guyana	5,900 (2,700-8,800)	1.2% (0.5-1.9)
Haiti	120,000 (110,000-140,000)	1.9% (1.7-2.2)
Jamaica	32,000 (21,000-45,000)	1.7% (1.1-2.5)
Suriname	3,700 (2,700-5,300)	1.0% (0.7-1.4)
Trinidad and Tobago	15,000 (11,000-19,000)	1.5% (1.1-2.0)

Source: UNAIDS Global Report on AIDS 2010

According to UNAIDS, roughly 10 percent of those infected with HIV in Haiti are children (UNAIDS/WHO 2008). This number indicates a massive need for prevention of mother-to-child transmission services, since most children are infected during pregnancy or through breast milk. With no preventative measures, there is a 30-45 percent chance that a woman will pass HIV to her baby through labor, delivery or breastfeeding (UNAIDS 2008). In high-income countries, this risk has been virtually eliminated due to the accessibility of health care and breast milk substitutes (WHO 2010). Unfortunately, in Haiti, the poorest country in the Western hemisphere, these resources are out of reach for the vast majority of pregnant women.

In an ideal course of treatment, HIV-positive women are put on a course of antiretroviral (ARV) medication at the 28th week of their pregnancies (UNAIDS 2008). These medications, combined with a Caesarean delivery, can reduce the chance of mother-to-child transmission to less than one percent. In some cases, the ARV medication and prenatal care are so effective that a woman does not need to deliver by Caesarean section because the viral load in her bloodstream does not pose a risk to the baby (Nolen 2007). However, in resource-poor settings, such as Haiti, these interventions are almost always out of the question.

Access to antiretroviral drugs is limited and unevenly distributed in poor countries like Haiti. Although this is a complex issue that cannot be fully examined here, a brief overview of ARV access in Haiti will highlight the difficulties of HIV treatment. In 2001, the Pan Caribbean Partnership Against HIV/AIDS (PANCAP) was established. This was a public-private partnership, including government, faith-based organizations and donor groups, created to promote prevention and treatment of HIV. In 2002, PANCAP signed an agreement with six pharmaceutical companies to provide access to cheaper ARV therapy (Avert.org 2010). However, wide differences in drug prices have slowed progress to provide treatment to those

living with HIV/AIDS. As of 2010, UNAIDS estimated that HIV treatment reached only forty-three percent of those in need in Haiti. Furthermore, of the estimated 120,000 people living with HIV in Haiti, only about 26,000 people were receiving ARV drug therapy (UNAIDS 2010). While not everyone who is HIV positive requires medication, the harsh living conditions of the Haitian poor can hasten the advance of AIDS. Despite the efforts of international AIDS activists to provide ARV medication to the poor, AIDS experts debate whether limited resources should be allocated to HIV prevention or treatment in developing countries (Nolen 2007; Epstein 2007). While the debate continues, many people in need of ARV medication must live without it.

After the 2010 earthquake, many clinics that had been providing ARV drugs were destroyed or reported that the clinic staff had lost contact with those patients in need of ARVs (IRIN News Service 2011). International agencies such as USAID and the Global Fund to Fight AIDS, Tuberculosis, and Malaria have provided grants in recent years to expand voluntary counseling and testing services for HIV. In 2006, a Haitian organization, FOSREF, was awarded a United Nations Population Award for its work providing basic training on reproductive health, including HIV and AIDS, to teachers and volunteers to educate their students and peers (Avert.org 2010). Community education programs are an effective tool against the spread of HIV, as I will examine in Chapter 3. However, the majority of Haitians are still in need of better HIV prevention and treatment services due to a combination of international power dynamics, crumbling infrastructure and social stigma surrounding HIV.

For HIV-positive women in resource-poor settings like Haiti, with limited access to prenatal care, the World Health Organization recommends a short, practical course of therapy, depending on the mother's viral load and whether or not she has regular access to antiretroviral drug therapy (AZT) (Giaquinto, Rampon, and De Rossi 2006). For a woman who does have

access to AZT and has a high viral load, the WHO recommends starting a course of therapy after the first trimester. The ideal drug regimen is a combination of AZT and a single dose of nevirapine during labor. After delivery, the baby should also receive a single dose of nevirapine, followed by seven days of AZT. Finally, the mother should take AZT and 3TC for seven days after the birth. This course of prevention is complicated and requires several types of drugs. In a setting with severely limited resources, the most cost-effective treatment recommended by the WHO is a single dose of nevirapine, given during delivery. This course of treatment carries a risk of drug resistance and may decrease the effectiveness of any subsequent use of nevirapine (WHO 2010). Unfortunately, even the most cost-effective preventative treatment is out of reach for many poor Haitian women.

Maternal Health Care

Most women give birth at home in Haiti – up to 75 percent by some estimates and even more in the rural areas (Gage and Calixtei 2006). Rural women in labor are often assisted by a traditional birthing attendant (TBA). Though these birthing attendants do not typically have any formal medical training, they are trusted in the community and their services are usually affordable for the average Haitian family, with fees costing a few dollars. Furthermore, studies have shown that there is little health risk to the mother and child if the pregnancy and labor progress normally (Pillsbury, Brownlee, and Timyan 1990; Harris 1987). However, if there are complications during childbirth, traditional birthing attendants are not equipped to provide the proper care and pregnant women can be in danger. Though traditional birthing attendants may not have a formal medical education, they are trained to recognize obstetric complications and refer pregnant women to a more sophisticated facility (Gage and Calixtei 2006). The series of

events that follow this moment can make the difference between life and death for a woman in labor.

Maternal mortality is one of the leading causes of death for women between the ages of fifteen and forty-nine worldwide. One woman dies in childbirth every minute. Ninety-nine percent of these deaths occur in the developing world (Averting Maternal Death and Disability 2011). There is limited data on maternal mortality, as maternal deaths often go unreported or are incorrectly categorized, even in developed countries. This is due in part to a lack of compliance with international standards of reporting and neglect of local physicians (Kao et al. 1997; Hogan et al. 2010). In Haiti, the maternal mortality rate is 230-1,000 deaths for every 100,000 live births (Barnes-Josiah, Myntti, and Augustin 1998). In the United States, a woman has one chance in 4,800 of dying in childbirth over the course of her lifetime. In Haiti, this risk is one in 44 (AMDD 2011). While no class-specific statistics exist, evidence such as the poor infrastructure in the rural areas suggests that this number is much greater among the poor. Impoverished Haitian women are not dying simply because childbirth is dangerous. They are dying because they are poor and Haitian.

Resources do exist in Haiti for clean, safe childbirth, but they are reserved for those who can pay for them. In terms of childbirth, rich Haitian women have more in common with women in the United States and Europe than they do with poor women in their own country. The majority of Haitian women live in poverty much like Acephie. Social and economic factors hinder their ability to make health a priority.

Women want competent care, especially in childbirth, when the health of their children is also at stake. However, in resource-poor settings like Haiti, poverty severely constrains a woman's healthcare options. In a study of maternal mortality in Haiti, the authors, Deborah

Barnes-Josiah, Cynthia Myntti, and Antoine Augustin, identified three delays that families make in seeking care in an obstetric emergency (1998). The first of these is the delay to seek care at all. Many families live far from emergency medical services and the cost of travel and care may be out of reach for them. Once the decision is made to seek care, the next delay occurs in reaching the medical facility. In several documented instances, families had to scramble to gather enough money for transportation and travel for hours – sometimes an entire day – to reach the nearest clinic or hospital, often on foot. When there was not enough money for two people to make the trip, pregnant women had to travel alone to get help. Finally, once the facility is reached, there is a delay in receiving adequate and appropriate care (Barnes-Josiah, Myntti, and Augustin 1998). This last delay is the most significant barrier in preventing Haitian women from dying in childbirth.

The old adage that bad news spreads quickly is particularly true in small, rural villages in Haiti. There is a widespread belief in rural Haiti that medical facilities provide poor quality care, especially government-run facilities. The experience of several women in the maternal mortality study shows that this perception is often true. In one case, after a family spent significant time and money to reach the hospital, the doctor simply was not there. In another example cited in the same article, the facility had no electricity and was unable to perform a Caesarean section (Barnes-Josiah, Myntti, and Augustin 1998). Health care facilities in rural Haiti suffer from a lack of supplies and an overworked, underpaid staff (GPRSP 2007). With these factors in mind, it is little wonder that many pregnant women and their families do not trust emergency obstetric services and must seriously weigh their options when considering care.

While some still subscribe to the misconception that rural populations do not seek out proper health care because of cultural or religious reasons, the fact is that Haitian women and

their families do want appropriate medical care. The examples above show that Haitian families are resourceful. In emergencies, they overcome tremendous challenges to seek out so-called sophisticated facilities, but they are often disappointed by the results (Barnes-Josiah, Myntti, and Augustin 1998). There is a significant need to improve medical facilities in Haiti and make them more accessible to the population. The lack of faith that Haitians have in government healthcare services is directly linked to their disillusionment with their government in general. In some cases, Haitians are more likely to trust a foreign healthcare provider than a Haitian provider, a topic I examine in Chapter 3. Haitian facilities, especially government facilities, must work to build up trust among the people, so that pregnant women will not hesitate to seek necessary care.

Mother-to-Child Transmission of HIV

In addition to childbirth, breastfeeding carries a risk of HIV transmission as well. The ideal scenario to prevent transmission is for a mother to give her infant a breast milk substitute such as formula. However, especially in resource-poor settings, many women cannot afford formula, clean water, or the fuel to prepare it. Aside from the cost, cultural and environmental factors significantly impact the way a mother chooses to feed her infant. In certain situations, not breastfeeding a child may be socially unacceptable. Particularly when a woman does not want people to know she is HIV positive, failing to breastfeed will draw attention to her and in some instances may arouse suspicion. Additionally, because poor Haitian women must work and raise other children, mothers may not have the time to prepare formula properly. Finally, infants fed with formula do not receive the nutrients and vitamins found in breast milk (WHO 2010). Despite the risk of HIV transmission, social and practical factors often make breastfeeding the most feasible choice for mothers.

In situations where a mother's best option is to breastfeed, the WHO recommends exclusive breastfeeding, followed by rapid weaning, a technique known as EBF. In a study in Malawi, another extremely poor country, researchers found that EBF is effective in preventing mother-to-child transmission, but it is difficult to implement (Østergaard and Bula 2010). The recommendations of doctors and health experts often conflict with family and societal expectations. Mothers are not raising their children in a vacuum. Deviating from traditional practices leads to intergenerational power struggles and social conflicts. A particularly significant barrier in the Malawi study was the power of paternal grandmothers. Mothers in the study found that grandmothers would give infants water or porridge in between breastfeeding, as is the local custom. However, giving infants food other than breast milk goes against the recommendations of EBF because it may damage the infant's stomach lining and make the baby more vulnerable to infection. The most successful women who implemented EBF disclosed their HIV status to their families, including their mothers and mothers-in-law. These women also had the support of their husbands about feeding decisions and did not live in the same home with their mothers-in-law. Finally, it also helped if mothers already had children and were experienced parents (Østergaard and Bula 2010). A supportive family environment and experience raising children could make the difference between successful implementation of EBF and passing HIV from mother to child.

A close analysis of this study indicates important lessons for PMTCT programs in all resource-poor settings. The first, and perhaps most obvious, is the conclusion that cultural and social factors often override medical advice. The pressure to conform to family and societal norms often outweighs the perceived threat of transmitting an illness. The second is that, although poor women may be well-versed in HIV treatment, they actually do not know much

about breastfeeding. More holistic counseling is necessary to ensure that mothers are able to raise healthy families, in addition to protecting them from HIV. Finally, women must have social capital and feel empowered in order to implement EBF (Østergaard and Bula 2010). International donors and campaigns need to focus on supporting women and families practicing EBF. Simply passing along information is not sufficient. However, it is also important to note that, despite the best efforts to support individuals and families, systemic change is also necessary so that families have the greatest possible access to economic, social, and political resources.

A study of maternal health services in rural Haiti also reveals some major barriers to preventing HIV transmission from mother to child. The vast majority of women do not use prenatal and delivery care services in rural Haiti. Almost 75 percent of births take place at home (Barnes-Josiah, Myntti, and Augustin 1998). A study published by the Population Investigation Committee looked at several factors, including the effect of poor road conditions, mountainous terrain, distance from the nearest hospital, whether or not a health worker was present in the neighborhood and the level of poverty in a woman's neighborhood. The authors noted that the perceived distance from a health center was just as important as the actual distance. Significantly, the study excluded the presence of traditional birth attendants and local beliefs about pregnancy and childbirth, because these could not be easily quantified (Gage and Calixtei 2006). The exclusion of these factors gives a limited view of rural birthing practices, but the study made some important observations about the potential for mother-to-child HIV transmission.

Overall, Haiti has a nationwide shortage of both equipment and trained personnel, especially in the rural areas, to assist women in childbirth. Haiti's only two birthing hospitals are

located in the capital city, Port-au-Prince, and rural health centers are poorly staffed and supplied, with limited services. The number of midwives is limited because of the decay of the health infrastructure and inequities in the distribution of health workers. The Population Investigation Committee study ultimately found that the higher the levels of neighborhood poverty and the more children a woman had, the less likely it was that she would use prenatal health services. In households with more income, a mode of transport (mule, bicycle, etc.) and a male partner contributing, there was a higher likelihood that a woman would seek out prenatal services. A woman with more years of schooling was also more likely to take advantage of health care during pregnancy and delivery. The study concluded that health care could be improved through investment in infrastructure and increasing the number of trained midwives in well-equipped facilities (Gage and Calixtei 2006). Medical education in Haiti is limited by class standing, as I will explain in Chapter 3.

Children with HIV

By 2006, 2.6 million children were infected with HIV worldwide. Over 1,400 children die of AIDS-related illnesses every day, most before the age of five. Half of all children born with HIV will not make it to their second birthday (UNAIDS 2008). A child's immune system is not fully developed at birth, which means that viruses hit them harder than an adult. HIV in children has a much more aggressive disease pattern and HIV-positive children are highly susceptible to opportunistic infections. When children contract these infections, their symptoms appear similar to other childhood illnesses common in developing countries, such as respiratory or diarrheal infections (UNICEF/UNAIDS 2010). Parents in poor countries, without access to HIV prevention and treatment, and with only limited access to medical care, may mistake HIV in children with something that requires less serious intervention.

A baby born to an HIV-positive mother may still be carrying the mother's antibodies, which can result in a false positive HIV test result. Children under eighteen months need a special diagnostic test that checks for the virus itself, rather than the antibodies the body develops to fight it. While adult tests of blood and saliva cost less than \$2, the test for children costs \$120 and requires special equipment and expertise (Nolen 2007). This is far out of budget for most national public health departments, Haiti included. Cheap alternatives to this test do exist. The WHO recommends that babies born to HIV-positive mothers be put on a course of prophylactic treatment in which the baby is given medication every day for six months to ward off infection. This treatment has been shown to cut mortality rates in half and it costs less than three cents per day (WHO 2010). However, many children in developing countries still do not receive this kind of medication because of poor planning and limited access to health services.

The treatment of children with HIV is complicated. Whereas adults can take medication in pill form, children who cannot swallow pills are given ARV medication in syrup form. This can cost up to five times as much as the pill form and often requires refrigeration. The doses must be carefully measured and taken at precise intervals several times per day. As children grow or develop resistance, the doses and medication must be constantly recalculated. On top of all of this, the syrups have a terrible, bitter taste (Nolen 2007). Finally, children must have adequate nutrition in order for the medication to be effective. Poor parents without much education must suddenly learn to follow confusing drug regimens and find a way to pay for them.

Aside from the medical aspects, raising a sick child can take a toll on family life. In anthropologist Nancy Scheper-Hughes work, *Death Without Weeping* (1993), she analyses the way family relationships develop within the context of extreme poverty and high rates of

maternal and child mortality in Brazilian shantytowns. Aside from the allocation of material resources, Scheper-Hughes describes how mothers reserve their love and affection for those children with the best chance of survival. Haiti also has a high rate of childhood mortality and families must cope with the likely possibility that not all of their children will reach adulthood, particularly if a child is infected with a chronic illness like HIV. In Haitian families, mothers are the primary caregivers for children, although the stress of tending to an ill child can strain all relationships within the family. Mothers around the world tend to put their children's health above their own, especially if resources are tight. If a mother is HIV-positive, neglecting her own health to care for her children puts her at risk for complications and can hasten the advance of AIDS (Nolen 2007). The loss of a mother is often catastrophic for poor families, particularly those with sick children.

Jealousy among siblings is an additional hurdle in raising a chronically-ill child. The expense and attention spent on the sick child can lead to resentment among the other children. In my travels to Tanzania, I met an HIV-positive boy whose parents had passed away from AIDS-related illnesses. His older siblings were so bitter at the special treatment he received that they refused to care for him after their parents died. He was severely neglected to such an extent that he failed to develop mentally. When he was discovered by aid workers at age nineteen, he had the appearance of an eight year old. After much coaxing, the boy's sister agreed to bring him for regular treatment at the local clinic, but she refused to acknowledge him in public and forced him to walk several steps behind her in the street. It was only after his health improved and he began to receive benefits from the aid organization that his family treated him better. In this case, family bonds were pushed to the limit and could only be saved by outside intervention. HIV can

deprive children of both their parents, as well as any opportunity of a productive life of their own.

The prevention of mother-to-child transmission of HIV is more complicated than biomedical intervention. The same kind of poverty that may drive a woman into a seeking a relationship for economic reasons can prevent a woman from seeking prenatal care. Larger environmental factors, such as the lack of trained medical personnel and equipment, often results in women giving birth at home, assisted only by family members or a birthing attendant with no formal training. Once children are born, social pressure may lead their mothers to conform to traditional breastfeeding practices, despite the risk of HIV transmission. Finally, the demands of raising a child with HIV and the added expense of time, money, and effort can lead to family conflicts. The harsh reality of life and agency in poor, rural Haitian communities can complicate even the simplest of medical interventions recommended by organizations like the World Health Organization and AIDS experts. In the next chapter, I explain some of the efforts to improve the quality of life in Haiti, including the unintended consequences of humanitarian aid, and the larger political and economic forces that affect the lives of the Haitian poor.

Chapter 3: The Future of PMTCT in Haiti

Prevention of mother-to-child transmission of HIV in Haiti will be an uphill battle, but there are concrete steps that can improve outcomes for mothers and their children. One of the most basic ways to improve access to health care is to improve infrastructure. Even in areas where health centers do exist, they are often subject to power outages or lack of clean water (Bentivegna 1991). As previously noted in Chapter 2, these centers are poorly supplied with outdated equipment. Projects to improve sanitation would ensure that children do not suffer from diarrheal diseases, the leading causes of death for children under age five in Haiti (UNICEF/UNAIDS 2010). Better roads would make it easier for patients to reach health services (RAND Corporation 2010, 89). However, the need for these services is nothing new. Non-governmental organizations have been working in Haiti for over fifty years, but the country's financial situation has actually been worsening (GPRSP 2007). Haitians constantly point out that the NGOs are becoming richer while Haitians are becoming poorer.

In this chapter, I discuss humanitarian assistance in Haiti in an attempt to determine whether international aid is the best way to prevent mother-to-child transmission of HIV. I begin with a description of Haiti's infrastructure and explain how it results in poor health for the Haitian people. I also analyze the January 2010 earthquake reconstruction and describe how poorly mismanaged the process has been. I explain why Haiti has been the target of so much foreign aid, yet the average Haitian is poorer than he/she was fifty years ago. I then transition to a discussion of the foreign aid system in Haiti, including how corruption and manipulation prevents aid from reaching the intended beneficiaries. Finally, I argue that capacity building may be a better way to help Haiti break the cycle of poverty.

Poverty in Haiti

Haiti is the poorest country in the Western Hemisphere, with over 80 percent of the population living below the poverty line (CIA World Factbook 2011). As discussed in the previous chapter on social class, this poverty has led to severe inequality within Haitian society. As a French colony, Haiti was one of the most prosperous territories in the world (Leyburn 2004, 15), but since gaining independence in 1804, Haiti has struggled to retain a stable economy (World Bank 2011). The Haitian government was required to pay reparations to France, which was not completed until the late 1940s, leaving the country deeply indebted (Heinl and Heinl 1978). During the Duvalier regime (1957-1986), aid agencies and international donors sent millions of dollars to Haiti, much of which was embezzled by the Duvalier families, while poor Haitians suffered (Easterly 2006, 147). After the fall of the Duvaliers, aid has continued to flow into Haiti (Easterly 2006), although poor Haitians continue to suffer.

In 2010, Haiti's economy had a negative 5.1 percent GDP growth rate, one of the worst in the world. The unemployment rate is currently over 40 percent, and those that do have jobs are primarily employed in the informal or agricultural sector. The country's infrastructure has been devastated by poor maintenance and deforestation. Haiti has one of the highest out-migration rates in the world and remittances are the primary source of foreign exchange (CIA World Factbook 2011). These unsettling statistics have led to an outpouring of support from the international community in the form of charitable donations and loans from multilateral institutions. Yet, despite the good intentions of donors, these numbers keep getting worse, in part due to the unintended consequences of aid.

In the book, *Reproducing Inequities* (2006), author Catherine Maternowska provides a detailed history of foreign aid in Haiti, specifically as it relates to health care. She argues that the

country's notorious political instability has been used as an excuse to suspend aid or go around government institutions to deliver aid in a politicized fashion. This has led to large-scale structural and social ills, such as sexism, as discussed in Chapter 1. Poor women in Haiti have the highest rate of maternal mortality in the Western hemisphere. Yet these women are caught in what Maternowska refers to as the "fertility paradox" (2006, 2) wherein women desire to have fewer children, but fertility rates are still high. This research revealed that Haitian women refused to use family planning services as a form of resistance or protest against injustices that have been imposed on them (Maternowska 2006). In instances such as those described by Maternowska, Haitian women actually act against their own interests specifically because of what they view as the damaging effects of aid.

The Haitian government must take an active role in improving health care and gender relations. Although there is a government agency charged with managing the health care system, The Ministry of Public Health and Population (MSPP), this agency was severely incapacitated by a lack of staff and poor organizational structure, even before the January 2010 earthquake. The earthquake destroyed what little health documentation the agency possessed and two hundred MSPP employees were killed when the building collapsed. In an analysis of Haiti's health care system after the quake, the RAND Corporation recommended that all health services (operation of clinics, hospitals, etc.) be transferred to the excess of health-related nongovernmental organizations in Haiti (2010). Currently, a lack of confidence in Haitian government institutions has resulted in NGOs operating independently, without any supervision from MSPP. The RAND Corporation report recommends that MSPP focus on developing a national health strategy, to which all NGOs and donor institutions must conform in the future (2010, 132). However, at

present, international organizations and the Haitian government are in a tacit struggle for control of the health care system and other social services while poor Haitians go without care.

In *Neglected and Abused* (1991), Dr. Joseph Bentivegna discusses his time in Haiti as a physician and the larger social factors that caused his patients' illnesses. Specifically, Bentivegna addresses malnutrition and how it affects the health of his patients. He points out that many of his patients perform manual labor jobs to earn money, similar to those discussed in the Chapter 1. However, the poor diet most Haitian laborers consume does not give them enough strength to sustain physically strenuous work. He also notes that malnourished pregnant women cannot get enough nutrients for their children to properly develop. This poor nutrition results in mental and physical deficits even before the child is born (Bentivegna 1991), which emphasizes the need for better holistic maternal health care.

Overpopulation is another issue that has caught the attention of international donors. Both Bentivegna and Maternowska describe the complicated nature of instituting family planning services in Haiti and they contend that traditional approaches to international assistance have not worked. Aside from the class differences that may exist between patient and doctor, international donors often advocate complex procedures with enduring consequences for patients. Both authors tell of foreign organizations inserting intra-uterine devices or giving women shots of Depo-Provera (Bentivegna 1991; Maternowska 2006). When complications arise from these treatments, the responsible organizations are often long-gone (Davidson, Joffe-Walt, and Glass 2010). If Haitian women have more agency in their own health care, there can be better outcomes in both lowering birth rates and prevention of mother-to-child HIV transmission.

Infrastructure in Haiti

Haiti's crumbling infrastructure is a significant barrier to international development, as well as a hindrance in the everyday lives of the Haitian people. As noted in Chapter 2, poor roads can lead families to delay seeking care in obstetric emergencies. That said, poor infrastructure affects Haitian families in less dramatic, but equally significant ways. For example, as Acephie's story shows, the roads connecting rural villages to markets in Port-au-Prince can sometimes take hours to traverse. Military checkpoints along these roads are frequently sites of exploitation and corruption, which I will examine further in the following sections. Roads are only paved in large cities like Port-au-Prince and, even then, they are only "paved" in the crudest sense of the word. Roads in the rural areas, such as the one travelled by Acephie, are unpaved and often flood during the rainy season. Severe deforestation has led to avalanches and mudslides during rainstorms, further destroying poorly-built roads and isolating rural villages until they can be cleared (Farmer 1994). Road conditions prevent women and their families from reaching the care they need.

Road conditions are only one of many problems with Haitian infrastructure. Access to clean water and sanitation is severely limited in Haiti, especially among the poor. Bentivegna suggests that the number of faucets in a country is a greater indicator of public health than the number of doctors (1991, 70). If this is true, Haiti's public health is in crisis. In a 2007 assessment of the country's progress toward Millennium Development Goal 7 – to reduce by half the percentage of persons without access to safe drinking water – Haiti was ranked as "Moving in the wrong direction." The percentage of people without access actually increased from 47 percent in 1990 to 54 percent in 2005 (GPRSP 2007, 42). By its own assessment, the Haitian government has failed to provide adequate water and sanitation services. In urban centers,

running water is available, although it is not safe to drink (GPRSP 2007). Drinking water systems were installed in the 1980s, but they are deteriorating due to lack of maintenance (GPRSP 2007, 24). Purification systems are available for those who can afford them, although most Haitians buy clean water in small quantities for household use. In the aftermath of the 2010 earthquake, international aid groups distributed free water to victims. However, for those in the business of selling water, this posed a problem, as imported goods have destroyed many Haitian industries over the past century and driven people into poverty.

In rural areas and shantytowns, only 25 percent of the population has access to drinking water (GPRSP 2007, 20). Many families draw water directly from streams and rivers (GPRSP 2007). Gathering water is traditionally women's work and many women and girls must travel long distances to get it (UNICEF 2004). Limited access to clean water and sanitation can exacerbate gender disparities (UNICEF 2004). According to a 2003 survey by the Haitian national government, 58 percent of schools do not have toilets and 23 percent have no running water (GPRSP 2007, 22). After a girl reaches puberty, she is often kept home from school during menstruation if the school does not have adequate facilities (UNICEF 2004). Missing several days of school each month sets back their education and is a contributing factor to the high drop-out rate among girls in Haiti (UNICEF 2004, 33-36). Without an education, people, and in women in particular, are less likely to find gainful employment and are more vulnerable to exploitation, as explained in Chapter 1.

The issue of waste disposal is connected to sanitation in terms of health. Haiti does not have a system of garbage disposal at the national level. The responsibility is left to municipal governments, which each handle waste disposal differently, if at all (GPRSP 2007). In Port-au-Prince, one can see garbage everywhere on the streets, although the President Martelly's

administration has made an effort to improve sanitation in recent months by making trash removal a priority on the streets of Port-au-Prince (Charles 2011). The disorganization of waste disposal is particularly dangerous in the case of medical or hazardous waste. When dumped into unsupervised, open landfills, this kind of waste can seep down into the water table and contaminate the soil, posing a threat to the population, especially in rural communities where people draw their water from streams and wells (GPRSP 2007, 46-47). Without clean water and adequate sanitation facilities, disease spreads more quickly and can worsen the symptoms of chronic illnesses like HIV.

Overpopulation and sanitation are also tied together in urban areas, where overcrowding strains existing structures that were never designed to be permanent. The lack of productivity in the agricultural sector has driven people to the cities in huge numbers, especially the capital city of Port-au-Prince. As noted in Chapter 1, migrants from the rural areas populate the slums and shantytowns that surround Port-au-Prince. In the early 1990s, the Haitian government created shelters that were intended to be temporary housing for these migrants. Instead, these temporary solutions have turned into permanent slums, such as Cité Soleil, where people live in cramped conditions with limited or no access to social services or basic sanitation (Maternowska 2006, 23-25). Temporary shelters were also erected after the 2010 earthquake, which still house thousands of displaced Haitians two years after the quake. Overcrowding and cramped living conditions exacerbate the spread of diseases like tuberculosis, which is spread by coughing (Bentivegna 1991, 71-73). Because these areas were never intended to house large populations, they lack proper drainage channels and waste management, which creates a breeding ground for the *Anopheles* mosquito, a carrier of malaria, a common ailment in Haiti (James 2008, 137). By definition, the people living in these slums are impoverished and unlikely to spend money on

healthcare, except in extreme cases. Self-diagnosis of illness is common among those too poor to go to doctor (WHO 2010). This can lead to a host of subsequent problems such as misdiagnosis and drug resistance. These problems can be directly tied to the pervasive problem of overcrowding.

Electricity is also scarce in Haiti. Most people rely on generators for power in the both the urban and rural areas. Even in the capital city, a newcomer is struck by the darkness in the evenings. In fact, the brightest lights come from the temporary earthquake shelters. Large lights in the camps were installed roughly a year after the earthquake, when it was discovered that rape was rampant in the camps under the cover of darkness (IRIN News Service 2010). As noted in the section on maternal health care, lack of electricity is a serious problem for medical facilities, as lack of electricity can cause a disruption in services.

Infrastructure improvements must be handled carefully. In interviews with Acephe's family and others in her community, the villagers traced their poverty directly to the Peligre Dam, an infrastructure project financed by the United States. During the U.S. occupation of Haiti (1915-1934), military engineers suggested damming the Artibonite River to improve irrigation, in the style of the Tennessee Valley Authority. The funding was granted by the Export-Import Bank, a U.S. federal agency, in the late 1940s and a hydroelectric dam was constructed at Peligre. Unfortunately, one of the unintended consequences of the dam was the flooding of the Artibonite Valley, which drove families like Acephe's off their productive land without compensation. Ultimately, the Peligre dam was a failure and it left the displaced families in poverty (Farmer 1994, 264). The dam project, designed and implemented by a foreign entity, disappointed the intended beneficiaries and hurt those who were most vulnerable.

Another example of development projects gone awry is apparent when one considers the case of the swine flu. In the mid-1990s, the U.S. government believed that the outbreak of swine flu in the country's pigs was coming from Haiti (Wilentz 2010). There has since been evidence to dispute such claims (Farmer 2005), leading one to believe that larger social and political factors may have been at play. In any case, the U.S. government led a campaign to eradicate the Haitian pig, a large black animal uniquely suited to Haiti's geography and climate. To compensate Haitian farmers for their loss, the United States provided pigs bred in Iowa. These pigs were smaller and less robust and could not survive in the harsh Haitian conditions. They quickly died out and, ultimately, their owners were left with nothing (Wilentz 2010, 157). In many poor countries, animals are a source of capital and are often sold for quick cash in times of need, or to pay for large expenses like school fees (Kidder 2004). Undoubtedly, the loss of a pig had significant consequences for Haitian farmers and their families.

International Aid for the 2010 Earthquake

On January 12, 2010, a 7.0 magnitude earthquake struck Haiti just outside the capital city Port-au-Prince. The earthquake left three hundred thousand people dead, another three hundred injured, and over one million homeless (RAND Corporation 2010, 1). While widespread destruction was a direct result of the earthquake, it was further compounded by Haiti's weak infrastructure and ineffectual institutions. Buildings collapsed due to poor construction, lax building standards and minimal code enforcement. Poor roads and inadequate airports slowed relief efforts. The lack of coordination among government agencies delayed effective response. The combination of these factors led the Inter-American Development Bank to conclude that reconstruction would cost nearly \$14 billion (Inter-American Development Bank 2010). The ongoing loss of life, productivity, and confidence due to the earthquake are incalculable.

Almost immediately after the earthquake, private citizens and governments around the world pledged their support. By one estimate, almost half of all U.S. households donated money to the Haitian relief effort (Davidson, Joffe-Walt, and Glass 2010). By June 2011, The United Nations Special Envoy to Haiti estimated that international donors had given Haiti over \$1.6 billion in relief aid and over \$2 billion in recovery aid (Office of the Special Envoy for Haiti 2011, 15). However, two years after the earthquake, more than half a million people remain in informal camps and much of the debris from destroyed structures still litters the streets (Quigley and Ramanauskas 2012).

The immediate question of “Where did the money go?” has several complicated answers that reveal inconvenient realities for those in the business of aid relief. The first step toward answering these questions must be an examination of the way the reconstruction was funded. Because of the massive scale of the reconstruction effort, international conferences were convened in the months following the earthquake to decide how best to manage donor funds. At the time, international donors and NGOs stressed that reconstruction efforts must be coordinated through the Haitian government. In practice, however, the majority of donor funds were channeled through large international NGOs (Kaufmann 2010). The perception that Haitian government institutions are weak, corrupt and ineffective may have been the reason that donors chose to direct funds through NGOs. However, in bypassing the Haitian government, this perception was enhanced and the Haitian government lost whatever sense of legitimacy and competence it had left. Furthermore, aid agencies are under pressure from donors to produce compelling results, to be discussed in the following section on food aid. Donors want to see hungry children receiving food, not government bureaucrats setting up technical infrastructure. This means that money that might have been better used to provide training or rebuild

government institutions often went to more appealing causes that could be easily demonstrated to donors. While using donor funds for short-term needs provides a satisfying, temporary solution, it also means that the Haitian government is not being supported in creating long-term solutions.

Another problem with the relief effort was the way in which contractors were hired to perform services for reconstruction. The staffing of aid agencies and relief organizations has long been a contentious issue. A common practice among aid agencies was to send staff from the donor countries to manage projects in recipient countries (Schwartz 2010; Moss, Pettersson, and van de Walle 2005). According to this old model of aid delivery, foreigners were always in charge, regardless of their knowledge of local culture and practices in the places they served. Effectively, this approach created a dependency on outside expertise and ensured that the local people would never be in a position to take over operations. In recent decades, many aid agencies have adopted a new approach by hiring local staff and fostering capacity building, a concept to be examined in a following section.

Though international NGOs may have realized the limitations of the old model of aid delivery, it seems that multilateral institutions and donor countries still abide by it. In the same way that the Haitian government was bypassed by donors, Haitian contractors were also overlooked in the reconstruction effort. Of the nearly fifteen hundred contracts awarded by the U.S. government from the time of the earthquake to April 2011, only twenty-three went to Haitian companies (Center for Economic and Policy Research 2011). Using Haitian companies to do reconstruction work could have provided a much-needed boost to the local economy. Favoring these companies could have also reduced cost, as using local labor would have been much cheaper than flying in workers from developed countries (Collier 2009). Average Haitians were also having a hard time being included in the reconstruction process. Following the

earthquake, representatives from multilateral institutions like the United Nations and the World Bank, as well as international NGOs, flooded into Port-au-Prince. However, Haitians were conspicuously absent or in low attendance at inter-agency meetings to discuss relief efforts. Representatives from Haitian NGOs either did not have the proper security clearance or could not spare staff to attend extensive meetings. Furthermore, these meetings were often conducted in English or French, not Creole, the local language spoken by the majority of Haitians (O'Connor 2011). Excluding Haitians from these meetings was another missed opportunity to benefit from their localized knowledge.

With over a million Haitians displaced after the earthquake, reconstruction efforts focused on housing. Relief agencies constructed temporary camps with makeshift tents for displaced people (IRIN News Service 2010). Haiti does not have proper sanitation systems in place for an operation of this magnitude, as previously noted. In one camp, there were only six latrines for a thousand people (Davidson, Joffe-Walt, and Glass 2010). The cramped conditions create a security risk, especially for women and girls. Despite international standards that routes to latrines must be safe, well-lit, and lockable (Inter-Agency Standing Committee 2006), this is not the case in many of the camps. Many women have reported being raped or attacked on their way to the latrines. No official statistics of rape in the camps exist, but the fact that rape is underreported in Haiti in general most likely means that the incidence is much higher than what has been reported (Amnesty International Report 2008). Roughly a year after the earthquake, unusually high birth rates revealed that many women had become pregnant as a result of being raped in the chaos and darkness of the camps (IRIN News Service 2010). Lights were eventually installed, but those living in the camps are still vulnerable.

One of the biggest concerns among international relief organizations was that the temporary shelters would not hold up during the rainy season, which began just a few months after the earthquake. In fact, many of the camps did flood. The overcrowded living conditions, combined with constant dampness, created a breeding ground for mosquitoes carrying malaria, tuberculosis and other communicable diseases. The outbreak of cholera in the summer and fall of 2010 can be directly traced to the cramped conditions in the camps (IRIN News Service 2010). This is of particular significance to those living with HIV, as their compromised immune systems cannot defend against the disease and, without treatment, they could die within hours of infection.

Despite these terrible living conditions, thousands still remain in the camps (Quigley and Ramanauskas 2012). In some cases, people have nowhere else to go. Their homes are still destroyed. In the case of migrant workers, many have no money to return to their home villages, even if they were inclined to do so (IRIN News Service 2010). Yet, in other instances, people have chosen to remain in the camps. Although conditions in the camps might be bad, for some people, they are better than they had before the earthquake. The presence of international relief efforts means that people in the camps have access to free food, water and social services, although aid agencies are in the process of phasing out these provisions (Davidson, Joffe-Walt, and Glass 2010). Access to these services is of particular importance to those who normally couldn't have afforded them and those in danger of stigmatization, such as people living with HIV. Women who may not have received prenatal care before the earthquake might have regular access to it in the camps. While not a long-term solution, the temporary camps might be an opportunity to introduce PMTCT services to pregnant women who are HIV positive.

The Problem with Food Aid

One of the most popular forms of humanitarian assistance is food aid. When aid agencies make appeals to donors in rich countries, pictures of hungry children are a prominent marketing technique. To the outsider observer in a wealthy country, the obvious solution is to give these children food directly. But development experts and aid workers in the field often argue against this method, saying that it can actually harm those that need help in the long run (Shah 2005; Oxfam 2005). Donors of good will with a desire to help the poor may not realize that the money they give is not being used in the best interest of those hungry children pictured in the aid agency poster.

In Haiti, as in many poor countries, a majority of the population depends on agriculture for its livelihood. With the exception of natural disasters such as droughts or hurricanes, research shows that the Haitian farmers usually grow enough food to feed their own families and sell their surplus (Schwartz 2010, 98-99), although profit margins have decreased over the years, as discussed in Chapter 1. Yields vary from season to season, but many farmers engage in intercropping, a process in which several varieties of plants and vegetables are grown in the same field. These crops are not harvested simultaneously, but rather they mature at different periods of the year, ensuring that staples are available year-round (Altieri 2000). Haitian farmers most commonly grow corn, beans, sweet potatoes, and peanuts, along with a variety of fruit trees and grains (Schwartz 2010). These are the same crops that were grown by the native Taino Indians who first inhabited the island (Wucker 2000; Leyburn 2004). They are particularly well-suited to Haiti's climate and provide enough nutrients to support a family. With an agricultural society dating back over 500 years, these crops have provided Haitian farmers a reliable way to earn a living.

Given the historically profitable nature of farming, it is striking that aid agencies and foreign governments donate hundreds of tons of food to Haiti each year. In some cases, food is donated in response to an emergency. A severe drought struck Haiti in the summer of 1997, which caused a hunger crisis. Multilateral institutions responded by donating emergency food aid – which did not arrive until the following summer, in the middle of a good harvest. In September of 1998, Hurricane George struck the island, causing widespread destruction. Again, multilateral institutions like the World Food Program and other relief organizations delivered emergency food in May 1999, in the midst of another good harvest (Schwartz 2010, 102). In both cases, the devastation caused by the shortage of food in one season was compounded by the surplus of food the following season which caused crop prices to plummet.

While these two instances could be blamed on egregious inefficiencies in relief response, food aid is an ongoing part of humanitarian assistance to Haiti. Many aid agencies, such as religious organizations, directly distribute food to people, in the style of soup kitchens in the United States. Other organizations, like sponsorship charities, distribute food in bulk directly to households in the community. While handing out free food solves an immediate problem, it also eliminates the need for people to buy food from local farmers, which in turn crashes the market. As over 70 percent of the population relies on farming for their livelihoods (CIA World Factbook 2011), the damaging effects of this market crash cannot be overstated. Farmers cannot sell their products and farming becomes less profitable over time, which drives rural populations into poverty. Facing poverty in the countryside, many emigrate to the cities, causing the overcrowding problems mentioned above. This discussion is not meant to disparage the good work done by aid organizations or to deny the needs of those who are truly hungry, but rather to point out the potential long-term damage that can be caused by short-term fixes.

Part of the problem with food aid stems from the way aid organizations are structured and funded. Some development experts claim that aid is tied to foreign policy goals (Easterly 2006, 145; Farmer 2005, 85-90). An analysis of some of the major aid organizations working in Haiti reveals that, at least in part, this claim is correct. Any agency that receives funding from USAID is obliged to follow certain policies. Among these policies is the stipulation that a certain percentage of their funding is actually donated food from USAID which must be sold on local markets (Wilentz 2010, 283; Schwartz 2010, 110). When aid agencies compete on the market with local farmers, this floods the market with excess product and drives down prices, following basic economic principles of supply and demand. Furthermore, imported food from countries that subsidize their agriculture sectors (such as the United States and France) are often cheaper than locally-produced food. This practice caused the collapse of the Haitian rice industry (Schwartz 2010, 109). Although importing food for sale is not considered aid, it does reveal conflicting policies of those countries and donors who claim to be helping Haiti.

Although aid workers in the field and many people in top positions at aid organizations realize the damage that food aid causes, they are obliged to operate in the current system because of the need for funding. Numerous studies and anecdotal accounts tell of the ineffectiveness of food aid and the fact that much of it does not reach those most in need (Bentivegna 1991; Schwartz 2010; Wilentz 2010; Oxfam 2005; Shah 2005). Donated food is sold or stolen before it reaches the intended recipients, in addition to crashing local markets, as described above. In many cases, food aid is donated to those who may not need it. This disconnect between donor and recipient touches on a larger issue of the way aid agencies operate in Haiti, to be discussed in detail later.

The fact that food aid is pushed on Haiti is connected to larger foreign policy goals of richer countries. Scholars across various disciplines (Easterly 2006, Schwartz 2010, Farmer 1994, Heintz and Heintz 1978) have long claimed that the United States government has interfered in Haiti in order to serve its own political agenda. While these scholars are generally referring to Haitian politics, the influence of rich countries can also be seen in international trade agreements. In 1985, the World Bank issued a report titled, "Haiti: Policy Proposals for Growth," which outlines the policy goals that foreign donors wanted to see implemented in Haiti (Wilentz 2010, 275-279). Essentially, the report recommends that the Haitian government use aid money to focus on exports, rather than social programs like health and education. While the World Bank and its rich member states issued the report as a "recommendation" for the Haitian government, international power dynamics and Haiti's need for foreign capital meant that the government had little choice but to follow the recommendations exactly. In order to implement an export-led growth strategy, the Haitian government agreed to create industrial zones in the major cities, guaranteed a low minimum wage, and suppressed labor unions. At the same time, the United States, France and Germany began to import their own, heavily-subsidized agricultural products, viewing Haiti as a new market for their own farming sectors. Haitian peasant farmers were being encouraged to come to the cities to work in factories, while at the same time finding that farming was becoming unsustainable due to the influx of cheap imported food (DeWind and Kinley 1988). This World Bank recommendation, which came to be known as simply, "The American Plan," helped to destroy the livelihood of Haitian farmers and create a justification for food aid and the institutions that supply it.

Problems with Aid Agency Operations

There is no official data on the number of non-governmental aid organizations (NGOs) working in Haiti, although some estimate there to be as many as ten thousand (Davidson, Joffe-Walt, and Glass 2010). Billions of dollars in foreign assistance and humanitarian aid have poured into the country since the American occupation ended in 1934, yet the average Haitian today makes 50 percent of what he/she make fifty years ago (Davidson, Joffe-Walt, and Glass 2010). A common complaint among Haitians is that the NGOs do more harm than good (Davidson, Joffe-Walt, and Glass 2010). Haitians point to countless examples of NGOs coming to Haiti with elaborate plans, starting projects, and then leaving when their funding is cut. In 2010, several months after the January 12th earthquake, two NPR reporters followed a poor Haitian woman in need of a canal for her mango tree. If this woman had a canal, she could have produced more mangoes, which could be sold to an exporter and helped her rise out of poverty. Over the course of the NPR story, a Haitian businessman reluctantly teamed up with an international NGO funded by USAID. The businessman, one of the primary mango exporters in the country, had avoided getting involved with NGOs for the same reasons listed here. The process of working with an NGO became extremely complicated, requiring months of paperwork, meetings, and compromises, when items would not fit into the predetermined budget. Finally, just as the project was about to be completed, the NGO's funding was cut and they left Haiti (Davidson, Joffe-Walt, and Glass 2010).

This NPR story is just one example of the disappointment and difficulty involved in the work of NGOs. Everyone involved seemed to have good intentions and to be working towards the same goal. However, unforeseen complications and unintended consequences ensured that the project would never work. First, there were the social differences between the Haitian

businessman and the farmer. Because of the class disparity described in Chapter 1, the two were unable to communicate effectively and, so, enlisted the help of the NGO. Next, there were the complicated procedures mandated by the NGO. All business had to be conducted through official channels, which cost money and time, while most dealings in Haiti are entirely informal. In the midst the activity, the January 12th earthquake struck, slowing down the entire process. Finally, the NGOs funding was cut with no explanation. What began as a quest for a canal – which would have cost \$2,000 at most – ended with further disillusionment with NGOs.

Corruption and Foreign Aid

Haiti suffers from both financial corruption and political brutality. Corruption in Haiti has been a problem for decades. Blatant political brutality during the Duvalier regime (1957-1986) drew international condemnation, but corruption did not end with the fall of Jean-Claude Duvalier in 1986. The poor are disproportionately disadvantaged by all forms of corruption, including graft, political disenfranchisement, and outright theft.

During the Duvalier regime, the poor Haitian masses suffered from intimidation and fear of political brutality. François Duvalier came to power with the help of the U.S. government, who mistakenly believed they would be able to control him (Farmer 1994, 44-45). Duvalier immediately took steps to solidify his power, including forming a private security force known as the *tontons macoutes*. Their name was derived from the mythical boogey-man that kidnaps sleeping children. The *tontons macoutes* were infamous for their cruelty. Their distinctive uniform of dark sunglasses, red bandana, and jean jacket struck fear into the heart of the average Haitian. President Duvalier tolerated no dissent and the *tontons macoutes* had full reign to suppress opposition by any means necessary, which usually meant violence. Average Haitians were exploited and stolen from, beaten, and arrested under false pretenses (O'Neill 1993;

Wucker 2000; Danticat 2008). *Tontons macoutes* infiltrated Haitian institutions, businesses, and the press to uncover and stifle any signs of rebellion in the population (Wilentz 2010; Perice 1997; James 2008). Those who spoke out against the regime were brutally silenced or forced to leave the country (Perice 1997), as in the case of Graham Greene and his famous novel *The Comedians* (1966).

While the Duvaliers were in power, there was little outcry from the international press about the human rights abuses committed by the *macoutes* (Farmer 2005, 80-84). In fact, the U.S. and other multilateral institutions sent financial support to the regime. The IMF awarded twenty loans over the course of the Duvalier regime, one of the highest rates awarded to any country (Easterly 2006, 147-149). François Duvalier seized control over all national institutions, including the Catholic Church in Haiti. Despite initial protests from the Vatican, Duvalier eventually was allowed to select his own bishops, declaring himself head of the Haitian Church (Farmer 1994). He also was named President for Life by the Parliament and he had the minimum age for the presidency lowered to eighteen (O'Neill 1993), allowing his son to take over after his death in 1971, the ultimate form of nepotism.

Jean Claude Duvalier continued his father's brutal legacy when he came to power. Though only nineteen years old and inexperienced, Jean Claude had a smooth transition into the presidency, thanks to his father's planning. Under an agreement with the Nixon administration, the young leader opened up the Haitian economy to the assembly industry, whereby goods manufactured by rich countries would be assembled in Haiti for extremely low labor costs. Though some development experts promote this kind of industry for developing economies, the way the deal was structured pushed the Haitian economy further into debt. Political dissent was violently suppressed during this time, while many Haitians were on the verge of famine. Years of

deforestation and soil erosion led to low food production and food riots (Farmer 2005, 86-87). The Haitian people were growing restless after nearly thirty years of Duvalier dictatorship.

In the fall of 1985, serious uprisings began around the country. Jean Claude Duvalier made several blunders which led to backlash among the Haitian people. Work, school, and commercial strikes brought the country to a standstill. Upon seeing the uprising and the impending fall of Duvalier, the U.S. reduced its aid to Haiti to save face. Finally, on February 7, 1986, Jean Claude Duvalier and his family left Haiti on a U.S. cargo plane. Over the course of the 29-year Duvalier regime, it is estimated that over sixty thousand people were murdered or disappeared (Farmer 1994, 128). In the period following Duvalier's departure, the U.S. government tried to take credit for deposing him. Henri Namphy led the new Conseil National de Gouvernement. Many Haitians were suspicious of his association with the Duvalier regime, but the foreign press seemed to love him (Moody, Brellis, and Diederich 1986). The new government quickly became a military junta filled with Duvalier's old cronies. The same kind of violence was carried over from the Duvalier regime (Treater 1987). Since the fall of Duvalier, Haiti has experienced limited periods of political progress, such as the election of Father Jean Bertrand Aristide in 1991. However, this progress is almost always quickly followed by political upheaval, which creates a further justification for intervention by foreign governments and international aid organizations, as described above.

High-level political corruption seeps down to every aspect of civil service in Haiti. The army and police in Haiti are notorious for extorting bribes from civilians, especially poor Haitians (Farmer 1994, 246-267). This has led to severe mistrust of authorities among Haitians. Many see no point in seeking help from police, as they are often mistreated, blamed for their own problems, or arrested without cause (James 2008, 143-144). During times of political

upheaval, violence was often used by the Haitian army as a means to punish support for the opposition. In some of the most horrifying instances, women were targeted for rape to punish their husbands for supporting opposition candidates. The stigma associated with rape caused many of these women to be abandoned by their families or suffer in silence, for fear of abandonment (James 2008, 148). Unfortunately, corruption and brutality in Haiti are not confined to the government. Regular Haitians are confronted with corruption in everyday life, even in an industry that claims to have the best of intentions – humanitarian aid.

Foreign aid has overwhelmed Haiti to the extent that it has been nicknamed the “United States of NGOs.” It has also created somewhat of a hand-out mentality among certain groups in Haiti. Some people have come to expect that they will simply be given food and other benefits by aid agencies, rather than having to work to support themselves. Unfortunately, these are not the people who need these benefits the most. The system of aid in Haiti has been manipulated in such a way that benefits flow abundantly to those who do not need them, while those who are really suffering often receive no help at all.



Map of NGO distribution in Haiti

There are an estimated ten thousand NGOs working in Haiti (Davidson, Joffe-Walt, and Glass 2010). Although these organizations exist with the stated purpose to help Haiti, many Haitians despise these organizations, claiming that they do not help regular people in need. A description of some common practices among aid organizations in Haiti may help to explain why. Many international NGOs are headquartered in Port-au-Prince. In fact, many aid agencies have headquarters in the capital cities of the countries in which they work (Kristof and WuDunn 2010, 161-162). Logistically, this may make sense, because the capital city often has the best infrastructure and is close to an international airport, which is necessary for top officials who frequently travel. However, this also means that the staff is far removed (physically, but also emotionally) from their operations in rural areas. This simple fact can lead to a host of other problems.

The neighborhood that houses many NGO headquarters is a suburb of Port-au-Prince called Petionville. NGOs in this neighborhood work out of converted mansions, alongside the richest residents of Haiti. Their operations often include new vehicles, walled compounds with security guards, constant electricity, and air-conditioning – all luxuries which their intended clientele could only imagine. They occasionally throw parties for foreign aid workers and visiting diplomats at their Petionville headquarters (Schwartz 2010, 81-83; Wilentz 2010, 106-110). These incongruities do not escape the attention of the poor Haitians they are supposed to be helping.

Operating an aid organization in a developing country is very complicated work, especially when staff members are not thoroughly familiar with a particular country. Because of Haiti's crumbling infrastructure and unique language and culture, working there is especially challenging. Furthermore, the political corruption described above makes it difficult to know

whom to trust in the local communities. As such, aid organizations often employ local NGOs or gate-keepers, residents of the targeted communities who help to facilitate operations. The “grassroots” trend in international development has been to employ local staff with information and access to the people the foreign NGOs hope to serve (Tinsley 2012). International NGOs consult with local organizations and gate-keepers to determine everything from logistical solutions to which community members should benefit from the agency’s services (Bailey 2008). These responsibilities give the gate-keeper enormous power in a community. Unfortunately, this power too often corrupts them and interferes with the agency’s efforts.

Bringing a large amount of money, goods, and services into an impoverished community is a formula for jealousy and resentment. Choosing one member of that community to control access to those things can compound those feelings. It is worth noting here that perceptions of what is corrupt vary according to local context. While favoring one’s family and social network to receive benefits may not align with an agency’s mandate, it may be perfectly acceptable and expected in certain communities (Bailey 2008; Transparency International 2011). However, the major problems with corruption in aid do not stem from slight cultural differences, but are actually blatant abuses of donor funds. One of the most common forms of corruption is overcharging an aid agency for supplies or contractor salaries (Duflo and Banerjee 2011, 244). With agency staff so far away in Petionville, many gate-keepers have realized that they will not verify information from their contacts in the field. Local staff may solicit bribes from residents to be put on beneficiary lists. In some of the worst cases, sexual favors are demanded in exchange for benefits and services (Bailey 2008). These scenarios destroy trust, both between the gate-keepers and the agency and also, in some cases, between donors and the agency.

It is not just gate-keepers that take advantage of the system. Regular Haitians have learned how to manipulate aid agencies as well. A contributing factor to diverting aid money is the way agencies and their associated “First World” countries are perceived by people in developing countries. People living in abject poverty, like the majority of Haitians, believe that there is limitless wealth in the developed world and any money that happens to disappear will never be missed (Tinsley 2012). Haitians also tend to see no distinction between foreign aid from the U.S. and multilateral institutions, and aid from international NGOs and charities. Because of the historically contentious relationship between Haiti and the U.S., and the fact that foreign assistance often has strings attached, aid is often viewed with suspicion (Moyo 2010, 25). Some critics of international aid have even equated it with a new form of colonialism (Easterly 2006, 290-293; Davidson, Joffe-Walt, and Glass 2010). Furthermore, the fact that corruption and exploitation are part of daily life in Haiti has made these practices more socially acceptable.

In his book, *Travesty in Haiti* (2010), Dr. Timothy Schwartz describes his time in Haiti and the countless scams he witnessed by people working with the Haitian aid industry. These scams included orphanages for children who had parents capable of caring for them or people soliciting donations for charities that did not exist. Common schemes were to misrepresent the number of people served or to exaggerate the benefits they received. In many cases, people running these scams seemed to have no fear that they would be caught or that anyone would bother to check up on them (Schwartz 2010, 141-148). This attitude is indicative of the lax evaluation standards of many international NGOs.

The saturation of aid agencies in Haiti has led many people to believe that they deserve a piece of the action. Experts in international development describe this as a hand-out mentality, wherein people feel entitled to benefits from foreign NGOs (Tinsley 2012; Schwartz 2010;

Bailey 2008; Transparency International 2010). However, the people that most benefit from this system of aid saturation and manipulation are those with the most cunning, education and connections – the kind of people that could probably find a way to support themselves legitimately. Consequently, the people that need this aid the most – poor, HIV-positive pregnant women with little education, for example – are the least likely to get it.

Capacity Building

One of the most effective ways to combat this hand-out mentality is through capacity building, or training local communities to take over aid operations and create a sustainable system for helping themselves. This concept is tied to the grassroots movement in international development, that is, the idea that local people have the best understanding of their needs and what will work in their communities. A key feature of capacity building is the belief that people have an innate desire to help themselves and rely on their own abilities (Tinsley 2012). Advocates of capacity building point out that international aid agencies often impose foreign cultural norms through their programs (either directly or inadvertently) and this cuts out those who are being helped from the decision and implementation process (Moss, Pettersson and van de Walle 2006). They also point out many of the dangers of foreign-run programs discussed here, such as the fact that many NGOs leave without warning or that they create dependency. Elements of capacity building are seen in the work of Dr. Paul Farmer and his organization, Partners in Health, one of the most well-known advocates for the Haitian poor. Among other initiatives, Partners in Health trains community health workers to administer medication and check-up on patients. As members of the local community, these people are the first to identify problems or recognize what will or will not work in their villages (Kidder 2004). The intent of capacity building is that donors can pay for technical experts to teach locals the skills they need

to support themselves and the locals can use and pass on that knowledge once the experts and international aid are gone.

However, capacity building has draw-backs as well. It takes much longer to train local residents to take over operations than to implement one-size-fits-all programs with foreign staff. Programs designed by and for local communities require consensus and each community member must participate. Public perceptions must also be adjusted. In some regions of Haiti, where the only doctors in recent decades have been white foreigners, some local residents only want to see the *blan*, or white man. They have difficulty believing that a Haitian doctor could be as well-educated or capable of treating them (Davidson, Joffe-Walt, and Glass 2010). Capacity building is also messy and inefficient. Building any system of trained professionals and infrastructure takes time, money, and sustained effort, even in the best conditions. In Haiti, conditions are anything but ideal. This also requires a shift in attitude for the development community. Rather than doing things quickly and pouring money into problems, capacity building requires that local communities come up with solutions, using their own limited resources. In some cases, this means that people will not get the help they need and some problems will not be solved in the most effective way. Finally, a particularly negative consequence of capacity building is the possibility that, once trained, local residents may use these skills as a ticket out of their communities to a bigger city or a more developed country, a concept known as brain drain, which plagues developing countries (Collier 2007, 112). All of these considerations must be taken into account when considering how best to help the Haitian poor create better lives for themselves.

Foreign intervention in Haiti has had serious consequences. Though some may argue that international power dynamic have created a system that purposely disadvantages the poor, even

those organizations that claim to do good can unintentionally hurt those they are trying to help. Capacity building may be one way to move forward, but it will take time and commitment. In my concluding chapter, I touch on a few areas for further research on prevention of mother-to-child HIV transmission, which may help Haitian families lead healthier and more prosperous lives.

Conclusion

As the previous chapters have shown, Haitian families are under extreme social and economic pressures which limit their choices. Furthermore, Haiti's low place in the international power structure is such that access to the best health care, education, and economic opportunities is denied to the vast majority of Haitians. Deeply-rooted conceptions of class, family structure, and gender limit the opportunities for poor Haitian families to break out of poverty. Though multilateral institutions like the World Health Organization have created a PMTCT protocol for those living in poverty, their recommendations fall short when faced with the reality of childbirth in rural Haiti. A brief overview of Haiti's infrastructure shows that even the simplest tasks like gathering water or taking goods to market can be incredibly difficult. Finally, in analyzing the overwhelming scope of humanitarian assistance in Haiti, one can see that the broken system of corruption and manipulation does little to help the most vulnerable populations, including poor, HIV-positive Haitian mothers with little education.

Prevention of mother-to-child transmission of HIV is a complicated topic with no simple solution. There are many aspects that cannot be covered here and many facets that require further exploration. Areas for future research include the role of Haitian midwives, public awareness campaigns for PMTCT, education for girls as a tool for HIV prevention, and male circumcision.

Haitian midwives could be a powerful force in PMTCT. Considering the fact that many Haitian mothers give birth at home, better training for Haitian midwives, or traditional birthing attendants, may be one way to ensure safer birthing conditions. Given the relatively simple WHO recommendations for PMTCT in resource-poor settings, as discussed in the section Pregnancy and HIV, it is possible that Haitian midwives could be trained to administer nevirapine during labor. In 1996, the Haitian Ministry of Health began a program to train midwives in emergency obstetric care and other safe birthing practices. This program appeared to be successful, until

budget cuts forced it to be shut-down (PAHO 2002). Perhaps foreign donors could target efforts to re-open this program, with the stipulation that those who receive training serve a minimum number of years in rural areas. The Haitian medical school in Port-au-Prince already has such a requirement for its graduates. However, with no system of verification or enforcement, many doctors simply ignore this requirement and stay in Port-au-Prince or leave the country after graduation (GPRSP 2007, 46). Establishing a verification system for both the midwife program and medical school would result in better access to care for rural Haitians. In the spirit of capacity building, using the already-established system of midwives to prevent HIV transmission from mother to child could be a cost-effective and socially acceptable tool.

Another area for future research is a public awareness campaign for prevention of mother-to-child transmission. Economists Esther Duflo and Abhijit V. Banerjee point out in their book *Poor Economics* (2011) that, because the poor have little or no education, they must rely on local knowledge and government authorities for information. However, because of the corruption and exploitation common among authorities in poor countries described above, the poor have little reason to trust information coming from their governments. Furthermore, it is much harder to conceptualize interventions intended to prevent something like a serious illness, especially if the intended beneficiaries do not have a thorough understanding of transmission. For example, parents who may not vaccinate children will often spend significant resources on medical care when their children fall ill (Duflo and Banerjee 2011, 64-66). If local health workers and other trusted members of the community are enlisted to educate people on mother-to-child transmission of HIV, this could encourage more families to seek out care during pregnancy and labor.

The best way to reduce mother-to-child transmission of HIV is to prevent the spread of HIV in the first place. HIV prevention has inspired a large body of literature and policy, which is much too extensive to describe here. However, one of the most relevant aspects of this research has been the education of girls as a tool for preventing HIV. An associated body of literature exists on educating girls as a tool to lower birth rates (Duflo and Banerjee 2011, 110-115). Education, in general, is a powerful tool against poverty. People with education are more likely to seek medical care for their children and themselves, and have better employment prospects (Chou et al. 2010; Ozier 2010). Educated populations are also less likely to tolerate poor governance and corruption, the likes of which have plagued Haiti for centuries.

An important caveat of education as a tool for HIV prevention is the type of message utilized. In 2003, President George W. Bush committed \$15 billion to combat the global HIV/AIDS pandemic. Most experts agree that President's Emergency Plan for AIDS Relief, or PEPFAR, was a mixed blessing for HIV prevention and treatment. Although the money PEPFAR provided was vital for the support of AIDS service organizations, it also came with an underlying social agenda to promote abstinence before marriage. Many critics have argued that the PEPFAR funds were used to preach abstinence at the expense of other prevention methods. Abstinence-only sex education has been widely discredited as ineffective and many experts fear that vulnerable populations, especially children, are not receiving enough information about condoms and other means of HIV prevention. Because PEPFAR is the largest source of HIV-related funding in much of the developing world, the incentive to push abstinence is leading some organizations to change their approach to attract more money (Avert.org 2010). This is another example of foreign funds being used to impose foreign cultural norms that conflict with cultural norms of the intended beneficiaries.

A method that has been effective in preventing the spread of HIV is to educate students about the type of people most likely to be infected with HIV in their communities. Prostitutes and people who travel frequently to large urban areas (such as migrant workers) have been heavily targeted for HIV prevention efforts (Collier 2003; IRIN News Service 2008). However, a significant portion of those infected with HIV are older, wealthy men. This population is often overlooked or not openly discussed in HIV prevention efforts (Kohler, Behrman, and Watkins 2007). In many poor countries, these men have comparatively higher rates of HIV infection, yet they are desirable partners for poor young women. A study in Kenya, another poor country with high HIV prevalence, found that simply informing young girls about the risk of “sugar daddies” reduced pregnancy rates by two-thirds with an older male partner (Dupas 2011). Furthermore, a related study, wherein girls were provided with school uniforms so they could stay in school, also reduced teenage pregnancy rates without any additional education on HIV prevention (Duflo and Banerjee 2011, 114-115). These studies show that young women are capable of assessing the risk of sexual behavior and often prefer to stay in school if given the option.

Another somewhat controversial method of HIV prevention has been studied in the past few years – male circumcision. In 2007, three randomized controlled trials revealed that male circumcision can reduce the risk of HIV transmission by sixty percent (Auvert 2005). Before these trials, observational studies reached the same conclusion. A closer analysis of these studies found that circumcision is highly cost-effective as a means of HIV prevention, when compared to the cost of treatment for an HIV-positive adult and any subsequent infections of sex partners (Weiss et al. 2008). More randomized control trials are needed to confirm the effects of circumcision, but the results seem promising. However, attempting to implement a policy of widespread circumcision will be a sensitive issue. The initiative has received little political

traction, probably because those in leadership in many developing countries with high HIV prevalence rates are well-educated older men from the elite class – precisely those who would be targeted for circumcision (Kohler, Behrman, and Watkins 2007). This further illustrates the divide between the elite and the poor in developing countries and places the responsibility for preventing HIV transmission on the shoulders of those least able to protect themselves.

Public health officials and activists in Haiti have worked hard to raise awareness of HIV. Radio programs and songs about HIV are broadcast across the country. People are encouraged to use condoms during sex and avoid intravenous drug use (Avert.org 2010). However, as earnest as these efforts are, they cannot contend with the social, political, and economic forces described here that put people at risk for HIV. Larger structural changes are needed to combat the spread of HIV, including the prevention of transmission from mother to child. The next generation of Haitian children deserves the chance to have healthy lives and improve their country for the generations that follow.

Bibliography

- Altieri, Miguel A. "Enhancing the Productivity and Multifunctionality of Traditional Farming in Latin America." *International Journal of Sustainable Development & World Ecology* 7.1 (2000): 50-61. Print.
- Amnesty International Report 2008: The State of the World's Human Rights*. New York: Amnesty International USA, 2008. Print.
- Auvert, B., et al., *Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 Trial*. PLoS Med, 2005. 2(11): p. e298.
- Avert.org. "HIV & AIDS in Uganda." *AIDS & HIV Information from the AIDS Charity AVERT*. Web. 15 Apr. 2010. <<http://www.avert.org/aids-uganda.htm>>.
- Averting Maternal Death and Disability. www.amddprogram.org. Columbia University Mailman School of Public Health. 2011.
- Bailey, Sarah. *Need and Greed: Corruption Risks, Perceptions and Prevention in Humanitarian Assistance*. Publication. Overseas Development Institute, 2008. HPG Policy Brief 32.
- Barnes-Josiah, Deborah, Cynthia Myntti, and Antoine Augustin. 1998. The 'three delays' as a framework for examining maternal mortality in Haiti, *Social Science and Medicine* 46(8): 981-993.
- Bentivegna, Joseph F. *The Neglected and Abused: A Physician's Year in Haiti*. Rocky Hill, CT: Michelle Pub., 1991.
- Biehl, João Guilherme., and Torben Eskerod. *Will to Live: AIDS Therapies and the Politics of Survival*. Princeton, NJ: Princeton UP, 2007. Print.
- Brennan, Denise. *What's Love Got to Do with It?: Transnational Desires and Sex Tourism in the Dominican Republic*. Durham: Duke UP, 2004. Print.
- Briggs, Charles L., and Clara Mantini-Briggs. *Stories in the Time of Cholera: Racial Profiling during a Medical Nightmare*. Berkeley, CA: University of California, 2003. Print.
- Center for Applied Linguistics. "Haitians: Their History and Culture." 18 Feb. 2004. Web. 6 Nov. 2009. <<http://www.cal.org/co/haiti/hedu.html>>.
- Center for Economic and Policy Research. "Haitian companies still sidelined from Reconstruction Contracts." 19 April 2011. <<http://www.cepr.net/index.php/blogs/relief-and-reconstruction-watch/Haitian-companies-still-sidelined-from-reconstruction-contracts>>
- Central Intelligence Agency. *The World Factbook 2011: Haiti*. 19 Nov. 2011. <<http://www.cia.gov/library/publications/the-world-factbook/geos/ha.html>>

- Charles, Jacqueline. "Michel Martelly Launches Housing Plan in Haiti." *The Miami Herald* 6 Oct. 2011.
- Chou, Shin-Yi, Jin-Tan Liu, Michael Grossman, and Theodore Joyce. "Parental Education and Child Health: Evidence from a Natural Experiment in Taiwan." *American Economic Journal: Applied Economics* 2.1 (2010): 33-61. Print.
- Collier, Paul. *Breaking the Conflict Trap: Civil War and Development Policy*. Washington, DC: World Bank, 2003. Print.
- Collier, Paul. *The Bottom Billion: Why the Poorest Countries Are Failing and What Can Be Done about It*. Oxford: Oxford UP, 2007. Print.
- Collier, Paul. "Haiti: From Natural Catastrophe to Economic Security" Report for the Secretary-General of the United Nations. January 2009.
- Danticat, Edwidge. *Brother, I'm Dying*. New York: Vintage, 2008. Print.
- Davidson, Adam, Chana Joffe-Walt, and Ira Glass. "Island Time." *This American Life*. WBEZ, Chicago, 21 May 2010. Radio.
- DeWind, Josh, and David Kinley. *Aiding Migration: The Impact of International Development Assistance on Haiti*. Boulder: Westview, 1988. Print.
- Doing Business 2010: Comparing Regulation in 183 Economies*. Washington (DC): World Bank, 2009. Print.
- Duflo, Esther, and Abhijit Banerjee. *Poor Economics: A Radical Rethinking of the Way to Fight Global Poverty*. PublicAffairs, 2011. Print.
- Dupas, Pascaline. "Do Teenagers Respond to HIV Risk Information? Evidence from a Field Experiment in Kenya." *American Economic Journal: Applied Economics* 3 (1). January 2011: 1-36.
- Easterly, William. *The White Man's Burden: Why the West's Efforts to Aid the Rest Have Done so Much Ill and so Little Good*. New York: Penguin, 2006. Print.
- Epstein, Helen. *The Invisible Cure: Why We Are Losing the Fight against AIDS in Africa*. New York, NY: Picador, 2007. Print.
- Farmer, Paul. *Pathologies of Power: Health, Human Rights, and the New War on the Poor : with a New Preface by the Author*. Berkeley: University of California, 2005.
- Farmer, Paul. "Sending Sickness: Sorcery, Politics, and Changing Concepts of AIDS in Rural Haiti." *Medical Anthropology Quarterly* 4.1 (1990): 6-27. Print.

- Farmer, Paul. *The Uses of Haiti*. Monroe, Me.: Common Courage, 1994.
- Gage, Anastasia, and Marie Guirlène Calixte. "Effects of the Physical Accessibility of Maternal Health Services on Their Use in Rural Haiti." *Population Studies* 60.3 (2006): 271-88.
- Giaquinto, Carlo, Osvalda Rampon, and Anita De Rossi.
 "Antiretroviral therapy for prevention of mother-to-child HIV transmission: focus on single-dose nevirapine. " *Clinical Drug Investigation*, 26.11 (Nov 2006): 611(17). Academic OneFile. Gale. University of Kansas Libraries. 12 Apr. 2011
- Ghosts of Cité Soleil*. Dir. Asger Leth. PDX, 2007. DVD.
- Greene, Graham. *The Comedians*. New York: Viking, 1966. Print.
- Harris, K. (1987) Beliefs and practices among Haitian American women in relation to childbearing. *Journal of Nurse-Midwifery* 32, 149±155.
- Heinl, Robert Debs, and Nancy Gordon Heinl. *Written in Blood: The Story of the Haitian People, 1492-1971*. Boston: Houghton Mifflin, 1978. Print.
- Hirsch, Jennifer S. *The Secret: Love, Marriage, and HIV*. Nashville: Vanderbilt UP, 2009. Print.
- Hogan, Margaret C. et al. "Maternal Mortality for 181 Countries, 1980-2008" *The Lancet*. Published Online April 12, 2010.
- Inter-Agency Standing Committee. *Protecting Persons Affected By Natural Disasters: IASC Operational Guidelines on Human Rights and Natural Disasters*. Washington, DC: Brookings-Bern Project on Internal Displacement, 2006. Print.
- Inter-American Development Bank. "Haiti Reconstruction Cost May Near \$14 billion." 16 Feb 2010. <<http://www.iadb.org/en/news/webstories/2010-02-16/haiti-earthquake-reconstruction-could-hit-14-billion-idb,6528.html>>
- IRIN News Service. "Haiti: Sex for Survival Puts Women at Risk." 3 Nov 2008.
 < <http://www.plusnews.org/Report/81268/HAITI-Sex-for-survival-puts-women-at-risk>>
- IRIN News Service. "Haiti: Women at Risk in the Camps." 9 March 2010.
 < <http://www.irinnews.org/Report/88360/HAITI-Women-at-risk-in-the-camps>>
- IRIN News Service. "Haiti: Risk and Treatment Amid the Rubble." 10 March 2010.
 <<http://www.irinnews.org/Report/88377/HAITI-Risk-and-treatment-amid-the-rubble>>
- IRIN News Service. "Haiti: HIV-positive People Especially Vulnerable to Cholera." 22 Nov 2010. < <http://www.irinnews.org/Report/91152/HAITI-HIV-positive-people-especially-vulnerable-to-cholera>>

- James, Erica Caple. 2008. Haunting Ghosts: Madness, Gender, and *Ensekirite* in Haiti in the Democratic Era. Pp. 132-156 in Good, Good, Hyde, and Pinto, eds., *Postcolonial Disorders*. Berkeley: University of California Press.
- James, Erica Caple. *Democratic Insecurities: Violence, Trauma, and Intervention in Haiti*. Berkeley: University of California, 2010. Print.
- Kao, Senyeong, Li-Mei Chen, Leiyu Shi, and Martin Weinrich. "Underreporting and Misclassification of Maternal Mortality in Taiwan." *Acta Obstetricia Et Gynecologica Scandinavica* 76.7 (1997): 629-36. Print.
- Kaufmann, Daniel. "Transparent Aid for Haiti's Reconstruction: Capture Matters." *Brookings Institution*. 30 Mar. 2010. Web. 12 Feb. 2012.
<http://www.brookings.edu/opinions/2010/0330_haiti_transparency_kaufmann.aspx>.
- Kidder, Tracy. *Mountains beyond Mountains*. New York: Random House Trade Paperbacks, 2004. Print.
- Kohler, Hans-Peter., Jere R. Behrman, and Susan Cotts Watkins. "Social Networks and HIV/AIDS Risk Perceptions." *Demography* 44.1 (2007): 1-33. Print.
- Kristof, Nicholas D., and Sheryl WuDunn. *Half the Sky: Turning Oppression into Opportunity for Women Worldwide*. New York: Vintage, 2010. Print.
- Leyburn, Graham James. *The Haitian People*. 4th Ed. Lawrence: Institute of Haitian Studies University of Kansas, 2004.
- Maternowska, M. Catherine. *Reproducing Inequities: Poverty and the Politics of Population in Haiti*. New Brunswick, NJ: Rutgers UP, 2006.
- Moody, John, Dean Brelis, and Bernard Diederich. "Haiti: End of the Duvalier Era." *TIME Magazine* 17 Feb. 1986. Print.
- Moss, Todd, Gunilla Pettersson, and Nicolas van de Walle. *An Aid-Institutions Paradox? A Review Essay on Aid Dependency and State Building in Sub-Saharan Africa - Working Paper 74*. Center for Global Development, 10 Jan. 2006. Web. 12 Dec. 2011.
- Moyo, Dambisa. *Dead Aid: Why Aid Is Not Working and How There Is a Better Way for Africa*. New York: Farrar, Straus and Giroux, 2010. Print.
- Nolen, Stephanie. *28: Stories of AIDS in Africa*. New York: Walker & Co., 2007
- O'Connor, Maura. "Does International Aid Keep Haiti Poor?" 7 Jan 2011. Slate.
<http://www.slate.com/articles/news_and_politics/dispatches/features/2011/does_international_aid_keep_haiti_poor/the_un_cluster_system_is_as_bad_as_it_sounds.html>
- Office of the Special Envoy for Haiti. "Has Aid Changed? Channeling assistance to Haiti before

- and after the earthquake." June 2011. <http://www.haitispecialenvoy.org/download/Report_Center/has_aid_changed_en.pdf>
- O'Neill, William G. "The Roots of Human Rights Violations in Haiti." *Georgetown Immigration Law Journal* 87 (1993). *HeinOnline*. Web.
<<http://heinonline.org/HOL/LandingPage?collection=journals&handle=hein.journals/geoimlj7&div=11&id=&page=>>.
- Østergaard, L., & Bula, A.. (2010). "They call our children 'Nevirapine Babies'": A Qualitative Study about Exclusive Breastfeeding among HIV Positive Mothers in Malawi. *African Journal of Reproductive Health*, 14(3), 213-222. Print.
- Oxfam International. *Food Aid or Hidden Dumping?*, Oxfam Briefing Paper. March 2005
- Ozier, Owen. "The Impact of Secondary Schooling in Kenya: A Regression Discontinuity Analysis," University of California at Berkeley Working Paper (2010)
- Pan American Health Organization 2002. *Health in the Americas*, Volume I and II. Washington, DC: PAHO.
- Perice, Glen A. "Rumors and Politics in Haiti." *Anthropological Quarterly* 70.1 (1997): 1-10.
- Pillsbury, B., Brownlee, A. and Timyan, J. (1990) *Understanding and Evaluating Traditional Practices: A Guide for Improving Maternal Care*. International Centre for Research on Women, Maternal Nutrition and Health Care Program, Washington, DC.
- Quigley, Bill and Amber Ramanauskas. "Haiti: Where is the Money?" 4 Jan 2012.
<http://www.haitiaction.net/News/BQ/1_4_12/1_4_12.html>
- RAND Corporation. "Building a More Resilient Haitian State." 2010.
- Ravitz, Jessica. "Women's Movement Mourns Death of 3 Haitian Leaders." *CNN*. Cable News Network, 20 Jan. 2010. Web. 7 Apr. 2012. <http://articles.cnn.com/2010-01-20/living/haitian.womens.movement.mourns_1_haitian-leaders-haitian-roots-haitian-woman?_s=PM:LIVING>.
- Republic of Haiti, Ministry of Planning and External Cooperation. "Growth and Poverty Reduction Strategy Paper." 2007.
- Republic of Haiti, National Constitution. 1987.
- Scheper-Hughes, Nancy. *Death without Weeping: The Violence of Everyday Life in Brazil*. Berkeley: University of California, 1993. Print.
- Schwartz, Timothy T. *Travesty in Haiti: A True Account of Christian Missions, Orphanages, Fraud, Food Aid, and Drug Trafficking*. Charleston, SC: urge, 2010. Print.

- Shah, Anup. "Food Aid as Dumping." *Global Issues*. 31 Oct. 2005. Web. 15 Feb. 2012. <<http://www.globalissues.org/article/10/food-aid-as-dumping>>.
- Singer, Merrill, Lani Davison, and Gina Gerdes. "Culture, Critical Theory, and Reproductive Illness Behavior in Haiti." *Medical Anthropology Quarterly* 2.4 (1988): 370-85. Print.
- Sorgen, Jeremy. "Haiti Liberte: Education The Cornerstone of Haiti's Progress." *HaitiAnalysis.com News and Analysis with the Grassroots in Haiti*. 11 Sept. 2009. Web. 6 Nov. 2009.
- Tinsley, Janet. Director of Regional Programs, Christian Foundation for Children and Aging. Interviewed by the author. 2 March 2012.
- Transparency International. *Preventing Corruption in Humanitarian Operations Pocket Guide of Good Practices*. Berlin: Transparency International, Internat. Secretariat, 2010. Print.
- Treaster, Joseph B. "Haiti a Year After Duvalier - Freedom Fills No Stomachs." *New York Times* 7 Feb. 1987.
- UNAIDS/WHO Epidemiological Fact Sheets on HIV and AIDS, 2008 Update.
- UNFPA. *State of World Population 2011: People and Possibilities in a World of 7 Billion*. New York: United Nations Population Fund (UNFPA), 2011. Print.
- UNICEF. (United Nations Children's Fund) "Haiti Donor Update 22 March 2006."
- UNICEF. *The State of the World's Children 2004: Girls, Education and Development*. New York: Oxford University Press, 2007.
- UNICEF. *The State of the World's Children 2007: Women and Children*. New York: Oxford University Press, 2007.
- UNICEF. *The State of the World's Children 2009: Maternal and Newborn Health*. New York: Oxford University Press, 2009.
- United States. Library of Congress. Federal Research Division. *Country Profile: Haiti, May 2006*. May 2006. Web. 7 Nov. 2009.
- Walton, David A., Paul E. Farmer, Wesler Lambert, F. Léandre, Serena P. Koenig, and Joia S. Mukherjee. "Integrated HIV Prevention and Care Strengthens Primary Health Care: Lessons from Rural Haiti." *Journal of Public Health Policy* 25.2 (2004): 137-58. Print.
- Weiss, Helen, James Khan, Kate Hankins, Jorge Sanchez, and Robert Bailey. *Proceedings of The Future Direction of Male Circumcision in HIV Prevention*. Los Angeles. 2008. Print.
- WHO, UNAIDS, UNICEF. *Towards Universal Access: Scaling Up Priority HIV/AIDS*

- Interventions in the Health Sector – Progress Report 2009*. Geneva, 2009.
- WHO, UNAIDS, UNICEF. *Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions in the Health Sector – Progress Report 2010*. Geneva, 2010.
- Wilentz, Amy. *The Rainy Season: Haiti--then and Now*. New York: Simon & Schuster Paperbacks, 2010. Print.
- Wolff, Laurence. *Education in Haiti: The Way Forward*. Washington, DC: PREAL, 2008.
- Wucker, Michele. *Why the Cocks Fight: Dominicans, Haitians, and the Struggle for Hispaniola*. New York: Hill & Wang, 2000.