

The Politics of Vodou: Aids, Access to Health Care and the Use of Culture in Haiti

Catherine Benoît

ABSTRACT: During the past few years, the AIDS campaign in Haiti has been targeting Vodou officiants and organizations. These awareness and training programmes inform officiants about the transmission and prevention of AIDS, tests for HIV and anti-retroviral drugs, or even try to encourage them to become involved in a medical referral system. These culturalist interventions are grounded in an essentialist concept of culture that can have harmful effects on the targeted groups. The concept of culture underlying such interventions is deconstructed along with the categories of traditional medicine and the 'tradipractitioner'. An approach to public health is advocated that would contextualize medical pluralism in Haiti.

KEYWORDS: culture, traditional medicine, public health, AIDS, Vodou, Haiti.

In the early 1980s, several anthropologists and doctors working in Haiti and the United States formulated a critique of the cultural approach to the AIDS epidemic in the Caribbean. Anthropologists and scientists reacted both to the Center for Disease Control's classification, in 1983, of Haitians as a high-risk group carrying the AIDS virus and to the claim that the Vodou religion¹ was a factor in spreading this pathology. More than twenty years later, radio broadcasts as well as articles in the press are still insisting on Vodou's role in the epidemic.

More recently, associations of persons living with HIV (hereinafter 'PLWH's), non-governmental organizations (hereinafter 'NGO's) and international organizations have been developing culturalist programmes for preventing AIDS and providing care. These organizations very often ask anthropologists to identify the cultural factors underlying the spread of the epidemic, the failure of prevention campaigns, the reluctance to be tested for HIV and the role played by Vodou officiants, who are held re-

sponsible for people's avoidance of medical and health care institutions. When responding to such requests, anthropologists (including the author of this article) might start by formulating a critique of the prejudices and concepts underlying these programmes. By proposing such a critical analysis, this article fits into the 'anthropology of policy' advocated by Arachu Castro and Merrill Singer (2004) as a response to the development of an 'unhealthy health policy', which has effects, whether foreseen or not, that are harmful to the targeted groups. At first glance, this criticism might appear to be an accusation regarding the intentions of these organizations—some of which have developed health and medical care programmes for patients or have backed the formation of support groups for PLWHs and of pressure groups to target the Ministry of Health and international sponsors. The trend towards culturalist interventions, however, does not originate in a denial of the fact that care is woefully inadequate. This denial has caused the epidemic to spread

and has hindered access to care. Instead, such interventions are based on a commodification and reification of Haitian culture, on an essentialist discourse proposed by certain organizations and the Vodou groups working with them. This article tries to deconstruct the categories of culture, traditional medicine and 'tradipractitioner' used by these organizations, and to suggest the benefits of an approach to public health in relation to Vodou that would conceptualize culture as the expression of social and political relations.

Culturalisation of the Epidemic

Social scientists and researchers have often described Haitian culture exclusively with reference to Vodou. This reductionist definition has prevailed in analyses of the cultural factors that account for the high prevalence of AIDS in Haiti and the fight against AIDS.

The *Plan national stratégique pour la prévention et le contrôle des IST et du VIH/Sida en Haïti 2002/2006* [National Strategic Plan for Preventing and Controlling Sexually Transmitted Infections and HIV/AIDS in Haiti] was drawn up in 2002 for the Haitian Ministry of Public Health and Population (hereinafter 'MSPP') for the period 2002 to 2006. On its second page under the heading 'Strategic Diagnosis of the Situation, it claims Vodou as being a factor in the 'social and cultural context' that might 'increase the risk of HIV-infection'. After declaring that 'certain sexual behaviour related to the observance of Vodou, which allows room for sexual freedom and socially recognized promiscuity, could increase the risks of HIV-infection' (MSPP 2002: 2), the Plan states that the 'ethno-cultural environment', along with 'the perception of man-woman relationships' and the economic context are liable to be among the 'environmental factors' conducive to infection. The 'ethno-cultural environment' is said to be the 'conception of supernatural illness, widespread in Haiti, which invokes a "locus of external control" that facil-

itates the spread of the epidemic; it takes away the individual's sense of responsibility with respect to prevention, opens up the possibility of non-medical treatment of AIDS [and] reinforces the risk of transmission (since the virus is a virtual, unrecognized entity)' (MSPP 2002: 7-8). This analysis is based on the conclusions of the *Enquête Mortalité, Morbidité et Utilisation de Services* [Investigation into Mortality, Morbidity and Use of Services], a survey carried out in 2000 for the MSPP according to which 19% of Haitians believe in the transmission of AIDS through sorcery, and 29% do not disregard this type of transmission (MSPP 2002: 7-8).

According to the National Strategic Plan, action in favour of PLWHs (home visits, grocery purchases, education in hygiene, the custody of orphans, training for self-help and support groups, loan agreements, etc.) concern a limited number of patients. They have little impact on the situation of the infected and those close to them because of a 'culture of resignation towards patients in a very poor general condition'. In the past few years, PLWH associations have pressured the Ministry of Health and its sponsors. Their complaints about lack of care, absence of treatment, and the lack of food and financial aid contradicts the Plan's conclusions.

In fact, practices and ideas, ranging from sexual taboos (of an unstated kind), promiscuity and marriage under customary law (*plaçage*) to high-risk heterosexual and homosexual practices in Vodou, are said to be cultural factors responsible for the upsurge in the AIDS epidemic. This list is isolated from the socio-economic context in which concepts or practices come into play. The list does not explain in what way these factors are conducive to the transmission of HIV. According to the research concerning PLWHs' therapeutical itineraries, which we conducted in Haiti and among the Haitian diaspora in the French Antilles, the idea that a sickness has supernatural origins or is caused by sorcery does not preclude a biomedical understanding of illness. Nor does it prevent people from tak-

ing the HIV blood test or medication (Benoît, 2004).²

It is not only the national strategic plan or NGOs whose view of culture is decontextualised. This view was also formulated in the declarations of international organizations (UNESCO, 2000). In fact, it fits in with a current in anthropology that E.B. Tylor introduced in the late 19th century. According to this British anthropologist, 'Culture or civilization, taken in its wide ethnographic sense, is that complex whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habits acquired by man as a member of society' (Tylor 1871: 1). To its credit, this definition refers to the ability of humans to create symbols and communicate with others through language, cultural facts and political systems. To its discredit, it too often results in an essentialist concept of culture, in particular of ideas and practices that seem alien to Westerners.

This view of culture raises four major problems with respect to the AIDS epidemic in Haiti:

First of all, understanding illness in cultural terms usually refers to a rigid concept of culture that tends to enclose individuals inside pre-existing systems of belief. Cultural factors are then said to be insurmountable, since the pervasiveness of religious beliefs and traditions keep people from assimilating information about public health. These traditions, however, in no way consist of a rigid entity, handed down from one generation to the next without discussion, negotiation or questioning. As the accounts of therapeutic itineraries collected from PLWHs show, these men and women, when told they were HIV-positive, switched from understanding the illness in the social terms of a Vodou worldview to seeing it in socio-political and bio-medical terms once they gained access to medical care (Benoît et al., 2005).

Secondly, this concept of culture prevents people from realising that ideas and, therefore, beliefs are dynamic. What do 'beliefs' mean? Stating a belief is not the same as actually be-

lieving in it. When HIV-positive persons say they have fallen victim to *mò sida* ('AIDS death', i.e., their symptoms are the result of sorcery), this does not mean that they understand the illness in terms of sorcery alone. This polysemous statement might be intended to maintain family and social relationships in a stigmatising context. It is safer to say they have been the victims of a spell, so that those close to them will seek a cure, than to declare that they have AIDS, since they would then be rejected. By taking what people say literally, this culturalist conception of culture assumes that educational campaigns will eradicate beliefs. Nevertheless I would argue that these beliefs might satisfy a need that has nothing to do with its obvious content. People might say they have fallen victim to *mò sida* to avoid stigmatisation, but still take their medicine because they know they have been infected by the virus (Benoît, 1997).

Thirdly, this decontextualised concept of culture leads to the development and implementation of primary prevention campaigns for rectifying the population's ideas and knowledge. The goal is to make individuals aware, to educate and inform them. The Information, Education, Communication Programmes (hereinafter 'IEC') for public health focus on this cognitive dimension and reduce decision-making to the level of the individual without paying any heed to the person's socio-economic environment. This simplistic view of decision-making, based on the individual's informed consent, minimises or overlooks the structural inequality underlying the proliferation of the illness: political crises, the breakdown of systems of education and health, instability and gender inequality—what Paul Farmer (2004) has described as 'structural violence'. As PLWHs in the poverty-stricken shanty towns of Port-au-Prince have emphasised, it was impossible for them to leave home in search of medication during the weeks when violence was rife. Compliance with treatment depended not on an understanding of the prescription but, instead, on the possibility to keep regular appointments

with doctors, to have access to food and potable water for taking the medication and to obtain social support. All these everyday struggles have turned AIDS into a 'pathology of power' (Farmer 2003).

The fourth problem raised by this view of culture is that it confuses social groups with cultural factors. Subaltern social groups, such as the 'poor, women, children and youth', are said to be 'general cultural groups' whereas 'families, male/female relationships, communities and migrants' are termed 'specific cultural categories' (UNESCO 2002: 12–13). There is no analysis of domination when a so-called cultural dimension is allowed to replace a social one. The beliefs and practices listed in the national strategic plan actually target the dominated strata of society. Customary marriages (*plaçage*) occur among the underprivileged, but the Haitian elite does not observe Vodou. This view presupposes that the economically privileged or well-educated do not have any Vodou beliefs, taboos or culture. Homosexual practices in Vodou are listed as a risky cultural practice, but not the bisexuality or homosexuality of affluent men in urban areas. Vodou officiants' practices—lack of confidentiality and privacy, insufficient knowledge about AIDS, sexual relations with clients—are criticised; but several PLWHs have stated that these also occur in medical circles. Rather than shedding light on the cultural context, the cultural dimension of illness, defined in this way, mainly reflects the image that dominant groups have of women, poor men, outcasts and people who observe Vodou.

This 'rhetoric of cultures' (Vidal 2003) tends to underestimate or overlook the political, social, economic and medical context that accounts for the spread of the epidemic and to minimise the responsibilities of governments, local health care establishments and international organizations. In this sense, this culturalist approach is a 'true symbolic violence' that, borrowing from Didier Fassin, deprives the Other of:

- its aspiration towards shared humanity: non-Western societies are not alone in turning to religion for the treatment of chronic or serious illness.
- the right to be different: there is no ideal-type of the 'individual' in the societies studied by anthropologists. PLWH itineraries provide evidence of a variety of therapeutic and spiritual means other than Vodou for coping with HIV-infection.
- rationality: behaviour deemed irrational by Westerners have rationales that are not related to biology or medicine. Treating an illness, elsewhere as in the West, brings into play medical rationales, spiritual motivations and affects. Recourse to Vodou does not normally preclude Western medicine whenever access to the latter is possible.
- their place in the "polis": by reducing men and women in non-Western societies to 'culture', we deny the social and political dimensions of their lives (Fassin, 2001).

The therapeutic itineraries of the thirty-one PLWHs interviewed during the research carried out in Haiti were constructed on the basis of how these persons, those close to them and their therapists gradually came to understand the causes and origins of AIDS in a context in which the supply of medical and health care is deficient and elementary needs (food, water, housing) are ever further from being satisfied.³ Since interviewees had learned they were HIV-positive between 1986 and 2004, it was possible to inquire into the changes made in their ideas about their illness, treatment and access to care over a period of up to nearly twenty years.

The date of infection and changes in the availability of medical and health care were decisive in these therapeutic itineraries. The longer ago the infection had started, the more frequently the illness was initially understood—very often due to family pressure—as having its origins in religion or sorcery. A biological interpretation emerged as non-medical treatments repeatedly

failed and anti-retroviral drugs gradually became available. For the recently infected, the period between the diagnosis and the switch from their initial interpretation (in terms of sorcery or religion) to a medical explanation was rather short, thanks to the development of PLWH associations and support groups, an anonymous AIDS hotline and the free distribution of anti-retroviral drugs. Once people obtained anti-retroviral drugs, joined PLWH organizations and took part in support groups, they stopped turning to religious practices (Vodou or Christian) and alternative treatments (such as 'renewing the blood' in Dominican Republic). They even began referring to religion in quite hostile terms. Some interviewees converted from Catholicism and Vodou to Protestantism or from the latter to Atheism. Some explained how their initial religious community had rejected them, since the interpretations made and instructions given by its officiants were so fiercely stigmatising and discriminatory. Changes in the understanding of AIDS and in the search for care paralleled forms of social organization and the social, political and sanitary contexts (Singer et al., 1988; Baer et al., 1997; Farmer, 1999). PLWH associations and support groups were essential to ensuring compliance with prescriptions for the taking of anti-retroviral drugs especially when symptoms vanished, and the illness might, once again, be interpreted in social or supernatural terms and/or treatment might be stopped.

Partnerships with Vodou Officiants and Organizations

Given the medical pluralism context of Haiti, a patient's therapeutic itinerary runs through various systems of care: herbal medicine, Vodou, 'healing' religions and Western medicine (Brodwin, 1996). For this reason, during the 1980s, the Ministry of Health tried to bring the representatives of Western medicine and Vodou together to combat tuberculosis. These

efforts were interrupted when, following the military coup of 1991 and subsequent embargo (1991–1994), the Ministry could no longer provide funding.

During the past five years, NGOs, international organizations, PLWH associations and support groups have launched initiatives for drawing Vodou officiants into the fight against AIDS. Awareness programmes and other actions have been introduced to inform and train them in the transmission of HIV, testing, preventive measures and anti-retroviral treatments. Some programmes try to set up a referral system so that officiants can refer their clients to testing and treatment centres. Out of the 109 Vodou officiants and midwives whom we met, more than forty had taken part in AIDS-related awareness or training programmes.⁴ Some of them had been visited by health educators and were working as individuals. Others belonged to Vodou associations interested in training their members to deal with HIV/AIDS issues.

These awareness and training programmes took place in two settings: either as part of a community health project or else independently. In the first case, a health care establishment or PLWH association organized individual or group training programmes, one or more days long, for Vodou officiants from a given region. When the purpose was to establish an effective referral system, health workers followed up on participants individually afterwards. When the programmes were organized independently of any community project, NGOs, international organizations and PLWH associations allowed Vodou associations to choose the participants to receive several days' training, but there was no follow-up. If success is measured by the knowledge acquired about how AIDS is transmitted or by the referral of clients for testing and medical appointments, these programmes, admittedly, had little impact. Few of the persons interviewed had learned how AIDS was transmitted, and few thought that any of their clients had contracted the disease. Some of them claimed to have had success in treating AIDS.

Eight out of these 109 persons had referred clients for testing or to medical centres. Through the detailed observations of healers, health officials, trainers, institutional care-givers and clients, we were able to identify the conditions under which referrals were made. These Vodou officiants had repeated or personal contacts with a health-care centre, PLWH association or NGO. Most of them had attended several training programmes, and there had been a follow-up visit to their court in which Vodou ceremonies were held. Those who had not undergone training had a personal relationship with employees in an AIDS organization and could recognize some of the symptoms of infection; some lived near a health care centre, PLWH association or NGO. All of them had the possibility of quickly contacting an organization if they wanted to refer clients to them. At the request of a neighbour infected with HIV, an officiant, who lived in one of the poorest districts of Port-au-Prince, was examining the possibility of setting up a support group for persons on anti-retroviral drugs who had no monitor (*accompagnateur*) to remind him/her to take their daily medicine and check whether they did so.⁵ In fact, most of these officiants had lost someone close to them to AIDS.

IEC campaigns or awareness workshops do not suffice for teaching Vodou officiants to identify the symptoms of HIV-infection and to refer clients for medical care. Officiants learned about the natural origin of AIDS-related symptoms and referred clients only when health care organizations or PLWH associations were conducting a programme nearby.

Might it be hard for Vodou officiants to understand how the virus is transmitted, since their practices try to cope with the family and social origins of pathology and to settle cases of sorcery? It is important to realise that interpretations of illness that we consider to be contradictory are, in fact, complementary. It is also necessary to take into account the broader context in which the information is communicated by the Ministry of Health and the economic sit-

uation of the trainees. As late as 2006, the Ministry of Health's brochures in Creole, which were circulating throughout the country and served as reference material for trainers, contained misleading information.⁶ It is thus hardly surprising that knowledge about the transmission of AIDS was incorrect. Healers were in the habit of telling their patients after treatment to consult a specialist in Western medicine. They felt that they had treated the origin of the illness (from a Western viewpoint, the social or supernatural origin) and that doctors could intervene at the level of the biological causes. Finally, given the enormous impoverishment of the country, many officiants now try to increase their income by retaining their clients until the terminal phase.⁷

The identity of the associations chosen to participate in some training programmes conducted independently of community health projects is questionable. Many Vodou officiants (*'servants of the lwa'*⁸, Vodou spirits) who do not belong to these associations have refused to have anything do with these programmes. To understand why they refuse, we must examine the contemporary social organization of Vodou, which has a 'fluid' pattern centred around a hard core, namely ancestor worship. Vodou has had intellectual, aesthetic (music, dance, plastic arts) and, nowadays, political ramifications (Bechacq, 2004: 41). The world of Vodou is organized around several types of affiliation, and a follower can lay claim to more than one of them. There are family cults of the *lakou* related to family and spiritual genealogy; urban temples (these are no longer based exclusively on bonds of kinship but also on relations in the locality); secret societies and Vodou associations.

The Vodou religion arose during slavery out of African cults and was retained differentially in local contexts. As a peasantry developed after independence in 1804, Vodou came to be rooted in family-owned land, *lakou* (from *la cour* [court] in French). This sort of Vodou—lineage-based in the words of André-Marcel d'Ans (1987)—brings together members of an

extended family (including its wards), 'servants' of the lwa and their initiates. Actual observances vary depending on the family history of the land owned. In no case is Vodou a homogeneous faith.

After many an anti-Vodou campaign organized by the Haitian state or Christian churches during the 19th and 20th centuries, the religion was officially recognized under President Aristide's second government (November 2000–February 2004). A Vodou Bureau was set up in the Ministry of Cults and Foreign Affairs in 2001. Organizations of officiants, intellectuals and artists, which had emerged in 1986 after the overthrow of Duvalier in order to protect officiants accused of having supported the dictatorship, favoured this institutionalization. In 1998, five of these associations, (Zantray, Mission Haloumandja d'Haïti, Vodou Dgohuon, Flé Zaka-syia and Bodé Nasyonan) formed the Fédérésyon Nasyonan Vodouyizan Ayisyen (FENAVO). The federation's board, the National Commission of Vodou Structuration, (CONAVO), lobbied to obtain recognition from government authorities. Under pressure from CONAVO and the Vodou Bureau, a decree of 4 April, 2003 acknowledged Vodou as an official religion and encouraged officiants to register with the Ministry of Cults and Foreign Affairs, while assuring them of government support. Baptisms, marriages and funerals—ceremonies created by CONAVO—are officially recognized by the state. Several officiants refused to join the associations federated in FENAVO since, according to them, it is promoting a Vodou that has nothing in common with the cults handed down as a family tradition. CONAVO's Vodou is taught during seminars conducted by the Haitian Vodou Church in the Bois Verna neighbourhood of Port-au-Prince—this has little to do with the passing down of knowledge and of lwa's from a 'servant' to initiates. CONAVO, which is now drafting a 'sacred book', advocates turning family cults into a monotheistic religion.

Since 2003, CONAVO is the Vodou organization with which NGOs, PLWH associations and

international organizations have been setting up awareness programmes and joint projects for reaching out to worshippers. The organizations developing programmes with CONAVO argue that it is easier, for administrative and budgetary reasons, to work with a federation with a duly constituted a board of directors and bookkeeping department than to try to reach Vodou officiants who practise outside any administrative or legal framework. I would argue that two other reasons underlie the decision to work with CONAVO.

The first has to do with the 'moral' benefits that NGOs, most of them Christian, derive from this collaboration. CONAVO has developed a normative culturalist discourse about AIDS that it propagates convincingly, as I have observed, on leaders in NGOs and international organizations and on American and European sponsors, both in Haiti and in international meetings. CONAVO's representatives consistently confirm the fantasies of Haitian and Western elites about Vodou being a religion with bloody and sexual practices that tend to spread HIV. To cure the situation, they propose sending 'battalions' of young initiates to the countryside to train officiants in the right practices for preventing the transmission of the virus. For these NGOs, the missionary period of conversions to Christianity and attempts to eradicate Vodou has yielded to a phase of cooperation with the 'servants of the lwa', this being evidence of a new religious tolerance.

The second reason behind the decision to work with CONAVO is the uncritical borrowing of the categories of traditional medicine and tradipractitioner as defined by the World Health Organization (WHO). This has led an entire generation of health officials to believe that Western and traditional medicine perform the same functions. This positions tend to reify the practices of healers. According to WHO (2002: 7), traditional medicine includes 'diverse health practices, approaches, knowledge and beliefs incorporating plant-, animal-, and/or mineral-based medicines, spiritual therapies,

manual techniques and exercises applied singularly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness'. The WHO definition is problematic on several counts. First of all, it reduces care to its biological and psychological aspects whereas care-giving is a practice involving not only minds and bodies but also the patient's family and social environment—in fact, a traditional healer might provide a treatment without seeing the patient. Secondly, a treatment's efficacy does not function in the same way in all medical systems, nor for all patients, depending on the system to which they turn (Waldram, 2000). Finally, this definition does not take into account the social status of the tradipractitioners, a category WHO created in order to legitimise the status of healers in its West African programmes. Healing is just one of the many practices and powers of the practitioners of non-Western forms of medicine.

In Haiti, as in several other countries, the men and women who are traditional healers may be large land-owners; they may be *chefs de section*, local officials who wield broad customary or official powers. Given their position of power, they are familiar with their community's social organization. This position determines their interpretations and treatments. Consultations for physical disorders end with a treatment that acts on the body, whether present or absent, and on the person's family and social relations, all of this through Vodou spirits. The 'servant of the lwa' might point out that the illness has its origins in the evil actions of a vulnerable person. For this reason, PLWHs do not want to see programmes develop in collaboration with Vodou officiants who thus become informed of their clients' (positive) sero-status. This might happen if these religious leaders were to appoint the persons to monitor PLWHs, a possibility discussed in several health care establishments. The knowledge might be used to stigmatise the HIV-positive or blame them, given their vulnerability, for acts of sorcery.⁹ Research into the knowledge and practices of

Vodou officiants cannot be limited to studying the aetiology, causes, classification and treatments of disease. It must take into account the social dimension and context of these practices and the probability of stigmatisation.

Public health programmes that take into account the cultural dimensions of the interpretation of illness, the search for care and the use of Vodou for therapeutic purposes must place these conceptions and practices in the context of the social relations that generate them (Massé, 1995). Successful programmes are, in fact, those that have been developed in close collaboration with community health projects. This collaboration has fostered knowledge about the network of care in the broadest sense, about therapists (doctors as well as Vodou officiants and midwives) and about the power relations involved in the delivery of care. Above all, these programmes have developed relations in the local vicinity that have proven indispensable to Vodou officiants who want to take part in the fight against AIDS.

Conclusion

This critical approach to culturalist interventions in public health is justified at a time when, in the history of the campaign against AIDS in Haiti, there are more and more programmes based on an essentialist conception of culture that are harmful to the population. The ideas and practices of HIV-positive persons do not form a closed system of knowledge, action and meaning that lies outside history. They are being updated in reaction to the availability of health care and inside the web of social relations (the family, community and PLWH associations) that partly define them. Likewise, the knowledge and practices of Vodou officiants are being updated inside the web of social relations woven around their position and understanding of how their communities are organized. The awareness campaigns and training programmes that have increased Vodou

officiants' knowledge about the transmission of the AIDS virus, its prevention and anti-retroviral drugs are those that have been part of community health projects that enable those individuals suffering from illness to sustain contacts with medical institutions or PLWH associations.

The analysis proposed herein does not simply criticise an approach to public health that takes into account the symbolic, cultural and social dimensions of Vodou but tries to explain that such an approach must be fully contextualised.

Apart from an analysis of the structural violence at the heart of AIDS epidemic in Haiti, medical anthropology can make a contribution to public health policy by describing more fully the practices of traditional healers and by critically analysing their social positions. It will be up to anthropologists to either accept or refuse to take part in such endeavours.

Catherine Benoît is Professor of Anthropology at Connecticut College. Her email address is: catherine.benoit@conncoll.edu.

Acknowledgements: This article was translated from French with the help of Noal Mellott (CNRS, Paris, France)

Notes

1. I have used the Creole spelling *vodou* to set this religion apart from the Hollywood depiction that has popularized 'voodoo' as a bloody, cannibalistic practice of magic.
2. This article is mainly of the result of research conducted in 2005 with Pierre-André Guerrier and Daniel Henrys on the knowledge and practices of Vodou officiants about AIDS-related issues and on the experience of persons receiving therapy who belonged to PLWH associations in Port-au-Prince and Saint-Marc, the two cities in Haiti where such non-profit organizations have been formed. This article also draws on the results of earlier research conducted by the author (1994–1998) on the island of St. Martin with the aim of studying the therapeutical itineraries of PLWHs at the French hospital there; some of the patients came from Haiti. The project carried out in 2005 was funded by UNAIDS, administered by UNESCO (207-AI 1000) and approved by Connecticut College's Institutional Review Board (2004-05.14). The earlier studies on St. Martin were funded by the French Agence nationale de recherche sur le sida (ANRS) and the Fondation pour la recherche médicale (FRM).
3. In 1998 (the most recent year for which statistics are available), Haiti had 0.25 physicians and 0.11 nurses per thousand inhabitants. By way of comparison, in 2000, the Dominican Republic had 1.88 physicians and 1.84 nurses; and the United States, 2.56 and 1.63 respectively (WHO 2006: 192, 198). The threshold of the water supply set by WHO and UNICEF is 20 litres/day, or 50 litres/day including bathing and laundry. Average consumption in Haiti is below 15 litres/day. By comparison, average daily consumption is from 200 to 300 litres/day for a European, and 575 litres/day for an American. Furthermore, 40% of Haitians do not have access to drinking water (UNDP 2006: 36, 293).
4. Out of respect for the confidentiality of the organizations that allowed me to attend their awareness or training programmes or meet Vodou officiants and midwives who had received training or were working with them, I shall provide a general account without mentioning the names of the organizations involved. Research took place in the following organizations:
 - PLWH associations: Association de la Solidarité Nationale (ASON) in Port-au-Prince; Fondation Esther Boucicaut Stanislas (FEBS) in Saint-Marc; Greater Involvement of People Living with AIDS (GIPA) in Port-au-Prince, Groupe de Recherches et d'Action Anti-Sida Anti-Discrimination Sexuelle (GRASADIS) in Port-au-Prince.
 - PLWH support groups: Promoteurs Objectif Zéro Sida (POZ) in Port-au-Prince.
 - Centres providing care: Association pour la Promotion de la Santé Intégral de la Famille (APROSIFA) in Port-au-Prince; Clinique Bethel in Fonds-des-Nègres; Hôpital Albert Schweitzer in Deschapelles.
 - International organizations: UNICEF.
 - NGOs: Care, Concern, Catholic Relief Services.
 - Vodou associations: Commission Nationale de Structuration du Vodoun (CONAVO), Réseau des Vodouïsants du Sud (RVS), Foyer des Vodouïsant(e)s pour l'Intégration Sociale (FOVIS).

5. Depending on the programme for distributing anti-retroviral drugs, appointing a person as a monitor is advisable or even compulsory.
6. According to these brochures, HIV could be transmitted during intercourse only if the mucous membrane had been 'injured'. As a consequence, many trainers and members of PLWH associations reassured people that the virus would not be transmitted if sexual relations remained 'calm'.
7. The GDP per inhabitant averaged out to US\$500 in the early 1990s, but had fallen to US\$332 by 2003, a drop of 67% (UNPD 2005: 13).
8. The word 'servant' is used for Vodou officiants, since their basic duty is to 'serve Vodou spirits'. Broader terms such as 'Vodou priest/priestess', 'oungan', or 'mambo' are exogenous categories.
9. In fact, the organizations that have developed awareness programmes as part of community health projects have refused to allow tradipractitioners to become monitors, as had been the case under the DOTS (direct observed treatment) strategy for coping with tuberculosis. These organizations are wary lest healers claim to have cured persons receiving anti-retroviral drugs.

References

- Baer, H., M. Singer and I. Susser 1997. *Medical Anthropology and the World System*, Westport, CT: Praeger and Greenwood.
- Béchacq, D. 2004. 'Commerce, pouvoir et compétences dans le vaudou haïtien', *Les cahiers des anneaux de la mémoire* 7: 41–69.
- Benoît, C. 1997. 'Sida et itinéraires thérapeutiques à Saint-Martin/Sint Maarten: représentations culturelles ou pratiques sociales?', *Dérades* 1: 79–88.
- 2004. 'Vivre avec le sida ou la drépanocytose: culture et géopolitique des itinéraires thérapeutiques des étrangers caraïbéens résidant à Saint-Martin', *Espace: populations et sociétés* 2: 265–279.
- Benoît, C., P. Guerrier and D. Henry 2005. *Sida, culture et pauvreté en Haïti: Représentations et pratiques liées au Sida*, Port-au-Prince: ONUSIDA-UNESCO project 207-AI 1000.
- Brodwin, P. 1996. *Medicine and Morality in Haiti—The contest for healing power*, Cambridge, MA: Cambridge University Press.
- Castro, A., and M. Singer 2004. *Unhealthy Health Policy: A Critical Anthropological Examination*, Walnut Creek, CA: Altamira Press.
- D'Ans, A. 1987. *Haïti: Paysage et société*, Paris: Karthala.
- Farmer, P. 1999. *Infections and Inequalities: The Modern Plagues*, Berkeley: University of California Press.
- 2003. *Pathologies of Power: Health, Human Rights, and the New War on the Poor*, Berkeley: University of California Press.
- 2004. 'An Anthropology of Structural Violence', *Current Anthropology* 45(2): 305–317.
- Fassin, D. 2001. 'Le culturalisme pratique de la santé publique. Critique d'un sens commun', in J. Dozon and D. Fassin (eds) *Critique de la santé publique—Une approche anthropologique*, Paris: Balland, 181–208.
- Massé, R. 1995. *Culture et Santé Publique*, Montréal, Paris and Casablanca: Gaëtan Morin.
- Ministère de la Santé Publique et de la Population 2002. *Plan national stratégique pour la prévention et le contrôle des IST et du VIH/Sida en Haïti 2002/2006*, Port-au-Prince, Haiti: Haiti Government.
- Singer, M., L. Davison and G. Gerdes 1988. 'Culture, Critical Theory, and Reproductive Illness Behavior in Haiti', *Medical Anthropology Quarterly* 2(4): 370–385.
- Tylor, E. 1871. *Primitive Culture: Researches into the Development of Mythology, Philosophy, Religion, Language Art and Custom*, New York: Henry Bolt and Company.
- UNDP 2005. *Situation économique et sociale d'Haïti en 2005*, Port-au-Prince, Haiti: UNDP.
- 2006. *Human Development Report 2006—Beyond Scarcity: Power, Poverty and the Global Water Crisis*, Basingtoke, UK & New York, NY: Macmillan.
- UNESCO 2000. *World Culture Report: Cultural Diversity, Conflict and Pluralism*, Paris: UNESCO.
- 2002. *L'approche culturelle de la prévention et du traitement du VIH/Sida*, Paris: UNESCO/ONUSIDA.
- Vidal, L. 2003. 'Travers culturalistes et pertinences du social dans l'approche du sida en Afrique', in UNESCO/ONUSIDA (eds) *VIH/SIDA—Stigmatisation et discrimination: une approche anthropologique*, NY: UNESCO/ONUSIDA (Études et rapports, n°20), 15–19.
- Waldram, J. 2000. 'The Efficacy of Traditional Medicine: Current Theoretical and Methodological Issues', *Medical Anthropology Quarterly* 14(4): 603–625.
- WHO 2002. *Traditional Medicine Strategy 2002–2005*, Geneva: WHO.
- 2006. *The World Health Report 2006: Working together for health*, Geneva: WHO Press.