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Culture and Mental Health in Haiti: A Literature Review

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Department of Mental Health and Substance Abuse

Mental Health, Disabilities and Rehabilitation Unit

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Preface

At the request of the Department of Mental Health and Substance Abuse of the World Health Organization, we have prepared a brief systematic review of the English and French-language literature on mental health in Haiti. This review focuses on relevant beliefs, help-seeking behavior, service utilization and both formal and informal resources for mental health. Our hope is that this report can provide some useful background for those unfamiliar with the local situation who hope to contribute to improving mental health services in the country.

This work was conducted by a team assembled specifically for this task by Laurence Kirmayer through the Culture and Mental Health Research Unit and the Cultural Consultation Service of the Jewish General Hospital. We would like to thank the many people who generously contributed their time and expertise: Kay Berckmans, Antonella Clerici and Teodora Constantinescu who helped locate literature; Pascale C. Annoual, Annie Jaimes, Aidan Jeffery, Dr. Myrna Lashley, Pierre Minn, Luisa Molino, and Andrena Pierre who reviewed the literature and wrote drafts of the text; Drs. Carlo Sterlin, Frantz Raphaël, Yves Lecomte, Cécile Rousseau, Danielle Groleau and Mark van Ommeren also reviewed and refined the text; and Drs. Eugene Raikhel, Rob Whitley who edited the drafts. In addition to coordinating the project, Laurence Kirmayer reviewed literature and edited the drafts and final manuscript. Producing this report in a short period has required a communal effort and all of the contributors worked intensively in the hope of making a contribution to the ongoing relief efforts and the long-term challenge of strengthening mental health services in Haiti.

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Abstract

This paper reviews and summarizes the available literature on Haitian mental health and mental health services. This review was conducted in light of the Haitian earthquake in January 2010. We searched Medline, Google Scholar and other available databases to gather scholarly literature relevant to mental health in Haiti. This was supplemented by consultation of key books and grey literature relevant to Haiti. The first part of the review describes historical, economic, sociological and anthropological factors essential to a basic understanding of Haiti and its people. This includes discussion of demography, family structure, Haitian economics and religion. The second part of the review focuses on mental health and mental health services. This includes a review of factors such as basic epidemiology of mental illness, common beliefs about mental illness, explanatory models, idioms of distress, help-seeking behavior, configuration of mental health services and the relationship between religion and mental health.

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1. INTRODUCTION

Rationale

On January 12, 2010, Haiti experienced a devastating earthquake. The earthquake registered 7.0 on the Richter Scale and was followed by numerous powerful aftershocks. The epicenter of the earthquake was close to the most densely populated areas of Haiti, including the capital and largest city, Port-Au-Prince. It is estimated that around 200,000 people lost their lives and thousands more have been injured. In addition, approximately 250,000 buildings have collapsed, the vast majority being residential, and many people have been rendered homeless overnight. Many hospitals and schools collapsed in the earthquake. Governmental and commercial buildings and infrastructure were also widely damaged or destroyed. Haiti suffered from lack of infrastructure and poverty even prior to this catastrophe, and now faces the challenge of rebuilding in the wake of great loss and trauma.

Governments, NGOs and international organizations such as the World Health Organization are contributing to an ongoing humanitarian response to the earthquake. This response includes the deployment of medical teams and humanitarian workers to Haiti to assist in addressing the manifold health needs faced by the Haitian population. This report is intended to contribute to these efforts by summarizing what is known about Haitian mental health and mental health services. This includes a review of literature and background information on basic epidemiology, common beliefs about mental illness, explanatory models, idioms of distress, help-seeking behavior, configuration of mental health services and the relationship between religion and mental health. We hope this review can inform short-, medium- and long-term efforts to improve mental health care and mental health services in Haiti by outlining social and cultural issues relevant to Haitian mental health care.

Search Strategy

Given the urgency of this report, we searched the main medical and psychological databases (MedLine, PsychLit) for the relevant information. We relied on Medline supplemented by Google Scholar to retrieve key books and grey literature relevant to Haiti. Search terms included the following, with the appropriate Boolean operators: Haiti*; mental health; mental illness; psychiatry; psychology. The multidisciplinary team working on this paper includes Haitian mental health practitioners and others familiar with the region who identified additional resources. Finally, we conducted manual searches of the reference lists of key papers and books for articles relevant to Haitian mental health. We included both English- and French-language literature. The search was conducted during the month of January 2010.

2. SOCIOCULTURAL CONTEXT

History of Haiti

Haiti is located in the Caribbean Sea, about 600 miles from Florida. It makes up approximately one third of the island known as Hispaniola, the other two-thirds consisting of the Dominican Republic. Before 1492, the island was inhabited by native Taíno/Arawak people. European contact occurred in 1492 when Christopher Columbus first set foot on the island. The island was slowly settled by Spanish colonists who set up an economy based on sugar cane cultivation. They enslaved the native population, who eventually perished as a people due to maltreatment, overwork in plantations and infectious diseases (Dash, 2001). Attempts to replace the Taíno/Arawak by indigenous people from Nicaragua were unsuccessful due to mortality, rebellion and escape. As the plantation economy grew and the original inhabitants perished, there was a need for more labor. The Spanish turned to the Atlantic slave trade for people to work on the plantations. French traders and planters also began to settle on the island. This led to competing European claims on the island of Hispaniola, especially between France and Spain. In 1697 the island was divided and the Western part (modern-day Haiti) came under French administration and was renamed Saint Domingue. As time progressed, the colony became France's richest and furnished fully two-thirds of her overseas trade.

Haiti was the first Black republic—the first country where the slaves fought their colonial masters and declared independence in 1804. This victory continues to be a source of hope, pride, encouragement, and motivation to Haitians and others. In its early years, however, the sovereignty of Haiti was not recognized either by the Roman Catholic Church or by nations that controlled trade across the Atlantic, including the United States and Spain. Despite these challenges, Haiti grew and flourished in the nineteenth century. However, internal and external forces combined during the twentieth century to undermine Haiti's hard won freedoms. Foreign governments and investors exploited Haiti's fragile position to maximize profit and trade. Within Haiti, political instability, mismanagement, corruption and oppression have contributed to collective suffering and under-development.

Demography and Diversity

Haiti has a population of more than 9 million people and is growing at a rate of 2.2% per year. In 2003, almost 60% of the population lived in rural areas (Caribbean Country Management Unit, 2006). The population of the country is young, with approximately 50% under 20 years of age. About 51% of the population is single and 44% married or cohabiting.

Creole and French are the official languages of Haiti; however French is written, spoken, and understood by only approximately 20% of the population, mainly by elite and middle class urban residents. Nearly everyone speaks Haitian Creole (Kreyol) as their first language. The lexicon of Kreyol is primarily French-based, but also includes terms originating in African and Arawakan languages, Spanish, and increasingly, English.

Haiti is marked by a powerful class hierarchy based on education, language, economic background and culture (Desrosiers & Fleurose, 2002). Valdman (1984) argues that French language has acted primarily as a "social "filter" in Haiti, restricting access to spaces of political, economic and social power. Like many other Caribbean countries, as part of the legacy of colonization and slavery, Haiti also has significant social stratification (and discrimination) based on gradations of skin tone (Trouillot, 1990). Lighter skinned people are more likely to be members of the elite and of higher socio-economic status. Contrariwise, darker skinned people are more likely to be members of lower socio-economic groups and to experience more marginalization.

In terms of education, 72% of the population has only a primary school education. Only 1% of the population has a university level education. There is a low level of literacy; about 80% of people in rural areas and 47% in urban centers are unable to read French. The state plays a very minor role in education. Overall, 92% of schools are non-state schools and about 82% of primary and secondary school age students attend private schools. The top schools are elite private schools, which are affordable only to a tiny segment of the population (Caribbean Country Management Unit, 2006).

Economic Context and Social Structure

Haiti is ranked 154 out of 177 countries on the Human Development Index, and is the lowest in the Western hemisphere. In 2008, the estimated per capita GDP was $717 (United Nations Statistics Division 2009). Income inequality is extremely high. For example, in 2001, the Gini coefficient (a measure of income inequality) for Haiti was 0.66, one of the highest in the world. Almost half of the population live in extreme poverty. The unemployment rate is also very high, reaching 49% in metropolitan areas, 37% in semi-urban areas, and 36% in rural areas.

The rural population depends on farming and agricultural production. Most houses have no indoor plumbing. Rural residents are often cut off from basic facilities and services. For instance, only 10% of the rural population has access to electricity compared to about 91% in metropolitan areas (Verner & Edset, 2007). The few state-supported hospitals are located in cities and larger villages. In terms of security, rural areas remain peaceful and are characterized by high levels of social cohesion. People living in rural areas may feel

safer in their daily lives than their urban counterparts who are confronted with much higher levels of crime and violence (Caribbean Country Management Unit, 2006).

In recent years, improving one's economic livelihood has involved three common strategies: (i) mobilizing assets such as cattle or food that can be sold following a natural disaster or during an economic slump; (ii) gaining access to labor markets and infrastructure that can generate income; and (iii) the ability to migrate to the capital (more than 75,000 migrants per year) or to industrialized countries (Caribbean Country Management Unit, 2006).

Given the country's political and economic situation, large numbers of Haitians have migrated to Canada and the United States in search of a better life and economic advancement (Gopaul-McNicol, Benjamin-Dartigue, & Francois, 1998). There are at least 500,000 Haitians in the United States, mostly in New York, Boston, Miami and coastal cities of Texas and Louisiana (Miller, 2000). There are also about 100,000 Haitians in Montreal. Smaller numbers of Haitians have migrated to countries such as France or other Caribbean island nations. About 30% of Haitian households (up to 44% of households in metropolitan areas) have relatives living in high-income countries (Caribbean Country Management Unit, 2006). The diaspora sends more than US $800 million annually to family and friends in Haiti.

Family and Gender Relations

Craan (2002) underlines the great importance of family in Haitian society, which is heightened in times of stress and difficulties. The family in Haiti is elastic and extended and usually includes a large network of relatives, neighbors, and friends (Dauphin, 2002).

In rural Haiti, the family is organized around the *lakou* (courtyard), in which clusters of extended family units form an interdependent community sharing a common courtyard. Work and child-care are divided among the families sharing the courtyard. Urban families are described as less interdependent, except in shantytowns where *lakous* are numerous. Middle class families in urban centers are organized around a model combining Haitian and Anglo-American elements. While authority is said to be held by the father, who is often absent, the mother remains the *poto mitan*, the central pillar of the family. In general, mothers have responsibility for the spiritual and emotional life of the family; fathers are responsible for finances, although mothers take care of the details (Bijoux, 1990, p. 31). Female-headed houses in Haiti are very common, particularly in urban areas (Magloire, 2008). In recent years, the pressures of poverty have disrupted the *lakou* system, leaving many families without the support and shared parenting afforded by the *lakou* (Edmond, Randolp & Richard, 2007).

Common-law unions ("*viv avek*" or "*plasaj*") are the most common conjugal patterns. *Plasaj* refers to a system in which a man may have several common-law wives and is expected to provide for each of them and for each child borne of that union. However, religious/legal marriage is still considered the most prestigious form of union (N'Zengou-Tayou, 1998). According to Danièle Magloire, who directs an organization for women's rights in Port-au-Prince,

> "In Haiti, the great majority of families are characterized by customary unions "*viv avek*" ["living with"] and by female single-parenting. Life conditions in these families are often very difficult especially when fathers refuse to take [financial] responsibility for their children. Moreover, an important proportion of children born from unknown [or undeclared] fathers, poses a serious problem at filial and social levels. The *viv avek* status also has consequences on the number of children (between 5 and 7 per woman) and on [the spread of] the AIDS epidemic… In the matrifocal system of Haitian families, given the economic context of the country, women shoulder several essential functions but face important discrimination on economic, judicial and educational levels" (Jaimes, Lecomte & Raphaël, 2008).

Gender roles are well defined within couples: women are responsible for market transactions, management of the family budget, food preparation, and care of the children. Generally, men are responsible for agricultural work, providing for the family, and repair and maintenance of the home (Miller, 2000). Various degrees of status exist for women, from *fanm mariye* (spouse), to *fanm kay* (house woman) or *fanm jaden* (garden woman). Rural women migrating to the city constitute one of the most marginalized groups in society. Many are unemployed, single parents, and end up living in the slums of Port-au-Prince, Cap-Haïtien and Gonaïves. Single mothers may have to resort to exchanging sex for cash or other resources for their families, or can be found vending goods and food on the street (Bell, 2001).

Elderly parents are highly respected and often cared for by their children or their relatives. If three or more generations are living in the house, power and authority are generally assumed in the following order: grandparents, father, mother, the eldest child and so on. Most Haitians have no old age pensions, savings or social security. Their children are their source of social security (Caribbean Country Management Unit, 2006). This is exemplified in the proverb "*Timoun se richès malèrè*" (Children are the wealth of the poor).

Children are raised with great discipline, and physical correction is often used in Haitian households. When children violate the rules or disobey, corporal punishment such as spanking, beating with a switch or a belt is considered an acceptable form of punishment.

In middle and lower income families, child rearing is shared by the parents and older siblings. Male children are often accorded more prestige than female children (Gopaul-McNicol, Benjamin-Dartigue, & Francois, 1998).

People who migrate often entrust their child to the care of a family member or a friend. It is also common practice for poor rural families to agree, mostly for economic reasons, to "give" their children to foster families in the hope that they may have better access to food, housing, and education. These youths called "*restavèk*" (stay with) often become unpaid domestic helpers and are particularly vulnerable to exploitation and high levels of physical violence and sexual abuse (Jaimes, Lecomte & Raphaël, 2008).

Religion

Religion plays a crucial role in all spheres of Haitian life, including politics, morals and health (Corten, 2000; Hurbon, 2004). Haiti is characterised by religious diversity, including: Roman Catholicism, Vodou (which combines West African traditions and Catholicism), and various Protestant traditions. Catholicism, Vodou and Protestant faiths have evolved in Haiti in interaction with each other and share key symbolic elements (Brodwin, 1992; 1996). Each religion cannot be understood without taking the others into account (Hurbon, 2001a). Since Catholic and Protestant traditions may be better known to non-Haitian readers, this section will focus on Vodou.

Vodou is widespread in Haiti and is practiced by the majority, including Haitians who identify as Catholics and, to a lesser extent, Protestants (Métraux, 1958). The name "Vodou" stems from the Fon word meaning spirit. The Code Noir of 1685 by Louis XIV made mandatory the conversion of slaves to Roman Catholicism. In an effort to hide forbidden African religious practices, the slaves identified their African deities with the saints of the Roman Catholic Church. The slaves could then give the appearance of strict adherence to Roman Catholicism, but were able to retain aspects of their West African religion, which manifested itself in Vodou (Hurbon, 2008).

In 1860, partially in response to the arrival of Protestantism and Freemasonry in Haiti, Rome approved a concordant and a bishop was consecrated in Port-au-Prince. Roman Catholicism became the official religion of the state. Although the actual distribution of religious affiliation and practice is unclear, common estimates are that about 80% of the population self-define as Roman Catholics and 20% self-define as Protestants (Gopaul-McNicol, Benjamin-Dartigue, & Francois, 1998). Protestant denominations are growing throughout Haiti. Both Protestants and orthodox Roman Catholics are less likely to practice Vodou. People from the lower class are more likely to adhere to beliefs and practices associated with Vodou. However, in times of great personal or collective crisis,

members of the upper and middle classes may also turn to Vodou for help, particularly when the causes of misfortune are unclear. Many people also may dance or sing vodou songs at times simply to draw strength from the music.

Vodou is not a homogenous religious system; there is great diversity in regional belief and practice (Najman, 2008). Most people who practice Vodou or "serve spirits" do not speak about it openly with strangers, clinicians, or others outside the tradition. Although individual knowledge and attitudes vary with education and religious affiliation, Vodou is part of the cultural background for most Haitians, regardless of their identity.

Vodou is not only a religion but constitutes a health care system, which includes healing practices, health promotion and prevention of illness and promotion of personal well-being (Augustin, 1999). Vodou provides information on how to promote, prevent and treat health problems, with theories of illness, treatment interventions, and prescriptions for behavior that are congruent with widely held explanatory models (Vornarx, 2008, p. 182). A first level of interpretation of illness in Vodou is based on the need to establish a harmonious relationship with the spirit world of the ancestors. A second level deals with the role of magic or sorcery attacks in which the afflicted person is the victim of a spell. According to the causal explanations of Vodou the health and illness of a particular person depends on his or her connection to tradition and place in the social and moral order and in a wider universe of being that includes the ancestors and the gods.

In Haiti, the African gods or deities are called *lwa-s* (loas) and represent the spirit of African ancestors, deceased family members and biblical figures. The *lwa-s* are seen as guardian angels. They can protect the devotee against the curse of an enemy and can be called upon for help in times of distress to provide guidance or to transform a situation (Desrosiers & Fleurose, 2002). To express themselves the *lwa-s* can inhabit the body of a person and this is called possession. Women are more likely than men to be possessed (Desrosiers & Fleurose, 2002; Miller, 2000). When possessed, the person may initially appear to lose consciousness and fall to the ground writhing and moaning. Once the person regains consciousness, the *lwa* can use her as a medium to communicate with other persons present. While the *lwa-s* can be a buffer to stress they can also be a cause of stress. If an individual fails to satisfy the *lwa-s*, they may retaliate by causing misfortune, poor physical health and mental illness (Desrosiers & Fleurose, 2002).

In Vodou, the *oungan* (Vodou priest) and the *manbo* (Vodou priestess) possess the knowledge of the tradition. They are endowed with power and are well respected in the community. The *bòkò* is considered to be a professional magician who can buy spirits to send curses, transmit malevolent spells and help someone achieve personal aims. Farmer (1990) found that Protestant, Catholic, and Vodouisant informants all acknowledged the possibility that sickness and misfortune can be "sent." Because one's enemy can use the supernatural to cause harm, Vodou may contribute to a sense of mistrust of others, though

it is also experienced as a supportive system for many Haitians living without formal health care (Desrosiers & Fleurose, 2002; Gopaul-McNicol, Benjamin-Dartigue, & Francois, 1998).

According to Brown (1989; 1991), Vodou is based on a vision of life in which individuals are given identity, strength and safety in a dangerous world through the thick fabric linking them together with other human beings, as well as spirits and ancestors. For this reason, disturbances in health or luck are a sign that relationships have been disrupted and may need to be mended. Vodou rituals heal individuals and groups "by exercising, strengthening, and mending relationships among the living, the dead, and the spirits" (Brown 1991: 346). The only way to control health and luck is through "the care and feeding of family, in the largest sense of that term" (Brown 1991: 346). For this reason, Vodou rituals usually involve feeding and caring for the spirits of ancestors. Vodou rituals work simultaneously on the sick physical body/self and on the larger collectivity of humans (Augustin, 1999).

In her volume on Haitian Vodou, Deren (1983) describes the *oungan*'s major role as medical, explaining that both an extensive knowledge of herbalism and the use of diagnostic rituals are central to healing in Vodou. *Oungans* search for "non-physical" or "unnatural" causes of sickness, which may be a "punishment for failing to serve [the] loa properly" (170). Deren emphasizes, however, that oungans are not opposed to biomedical treatments and may refer patients whose cases are beyond their scope of expertise.

Protestant and Catholic Churches and religious practices in Haiti help people cope with mental and emotional problems, and provide a parallel system of healing. Religion in Haiti offers a sense of purpose, consolation, belonging, structure and discipline. Religion can increase self-esteem, alleviate despair and provide hope in very difficult and trying circumstances. Health professionals working in Haiti may use spiritual leaders as allies because they can encourage clients to seek help and adhere to recommended treatments. Religious and spiritual leaders can serve as 'consultants' or 'co-therapists'. They may be trusted more readily than conventional mental health professionals or medical institutions.

Table 1. Health care as a function of cultural systems (Adapted from: Sterlin, 2010)

	Cosmocentric Culture of Haiti	**Anthropocentric Culture**
Ways of Being (Worldview)	Human beings are only a particular form of condensed energy drawn from the great cosmic and all-encompassing cosmic Being, whose primary concern is to achieve and maintain harmonious synergy with the universal energy.	Humans are the centre of an imperfect universe that they must understand, explore, master, transform, exploit, etc.
Concepts of the Person	The person has four dimensions: • Kò kadav ('body'); • Lonbraj ('shade'); • Gwo bon-anj ('big good angel'); • Nam/ti bon-anj ('little good angel').	The person has two dimensions: body and mind.
Health	Health is the state of "well-being in connectedness" to the environment which includes: • the non-human environment (land, plants, animals, air, forces of nature, etc.); • the human environment (nuclear and extended family, network of close allies, collectivity, others); • ancestors and spirits (the invisible). The indicator of health and wellbeing is the experience of harmonious integration in the environment ("ontonomy").	Health is the state of well-being that results from the optimal functioning of organs and systems defined by physiological and biochemical parameters. The influence of the environment is mainly physical (e.g. quality of air, food, etc.). There is modest recognition of the importance of the social environment. The indicator of health and well-being is individual autonomy and performance.
Illness	The state of "being-ill-with" results from a loss of harmony between the components of the person and/or between the person and one or more elements of the environment.	The state if ill-being results from a perturbation of functions of an organ or system.
Origins of Illness	• Non-observance of the rules that govern the human relationship with the physical environment; • Non-observance of rules of hygiene • Non-observance of ethical rules • Malign influence of others (poisoning, sorcery) • Non-respect of the rites or prescriptions regarding the ancestors and/or spirits	• Manifestations of hereditary or genetic problem; • Non-observance of rules of hygiene (nutrition, toxins, microbes, etc.) • Pathogenic interpersonal factors (poor emotional care, loss, trauma, etc.) • Psychosocial stress
Classification of Illness	• *Maladi Bondyè*: domain of visible or "ordinary" physical illnesses; can be healed with the aid of Western medicine or a *doktè-fèy* (traditional healer); • *Maladi fè-moun mal* (or *maladi diab*):domain of the invisible, secret or magic; can be healed by intervention of a *bòkò* or a traditional *oungan* practitioner	• Physical illness • Mental illness • Psychosomatic illness All require the aid of a biomedical physician and may not improve without medical attention.

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	• *Maladi lwa*: domain of the invisible spiritual; can be healed by an *oungan*.	
Death	• Normal phase of the cycle of energy allows the ill-person to achieve the status of ancestor, spirit, etc. • Meaning varies with type of illness (*Bondyè, diab, lwa*).	• Fatal result of a biological disequilibrium that medicine has not yet mastered. • Experienced as a failure for the patient as well as for the medical practitioner.
Experience of Illness	• Polymorphism and volatility of experience of symptoms (metaphors) • Absence of (occidental) anatomical references • References to energy and to one or other elements of the person. • Few links made between malaise and affects, thoughts, fantasy.	• Clear and univocal character of symptoms • Reference to anatomy • Fixed relationship to malaise. • Reference to physical or psychological. • Links to affect, fantasy, etc.
Mode of Healing Intervention	• Divination of the nature and meaning of malaise. • Mediation with the universe of spirits • Prescription of measures include rituals • Realignment of energies. • Active participation of patient (search for plants, pilgrimage, dance, etc.). • Mobilization of social networks and knowledge networks. • Links with the moral, social and political. • Participation of the client in remuneration of the healing (financial or otherwise).	• Elaboration of a rational diagnosis related to the nature and cause of illness (according physiopathology or psychopathology). • Recourse to medical technology to confirm diagnosis. • Spirituality is suspect or an index of pathology. • Prescription of measures to restore equilibrium (medication, nutrients, exercise, etc.). • Interventions centered on the individual. • Financial participation of the patient is ethically and politically unacceptable when it opens the way to abuses.

3. HEALTH IN HAITI

Major Causes of Mortality

According to PAHO/WHO (2003), the main causes of infant death in Haiti include acute diarrheal disease, intestinal infectious diseases, infections of the perinatal period, malnutrition and acute respiratory infections. In schoolchildren common causes of death include infectious and parasitic diseases. Among adolescents, the main causes of death are HIV/AIDS, assault, homicide, tuberculosis, typhoid and maternal death. Female adolescents may have high rates of exposure to violence and sexual abuse. In adults, common causes of death include AIDS, intestinal infections and maternal causes (e.g. arterial hypertension, eclampsia, complications of labor). Among the elderly, causes of death include non-communicable diseases, diseases of the circulatory system, malignant neoplasms of the digestive organs, tuberculosis and HIV/AIDS. Because Haitian patients often expect health professionals to ask about the presence of a series of symptoms (in order to pose a diagnosis), knowing about these prevalent diseases may help in the exploration of symptoms.

Explanatory Models of Illness and Idioms of Distress

Haitian culture provides a range of explanations for illness drawing on commonly held cultural, religious and social beliefs. Explanatory models can determine help-seeking behaviour and service utilization. In Haiti, illness explanations and help-seeking behaviors vary greatly depending on factors such as location, religion and social class. Individuals use resources pragmatically, and often hold multiple or hybrid models of health and illness. As a result, the same person may seek help from multiple sources, when available.

Haitians divide illnesses into several broad categories, including: *maladi Bondye* (God's disease, or those of "natural" origin), *maladi peyi* ("country", or common, short-term ailments), *maladi moun fè mal* (magic spells sent because of human greed), and those of supernatural origin, *maladi lwa* ('disease of God') and *maladi Satan* (Satan's or "sent" sicknesses) (Sterlin, 2006; See Table 1).

Many Haitians also use a humoral theory of health and illness. Imbalance of hot and cold within the body are believed to be causes of natural illness. These imbalances can stem from environmental elements such as rain, wind, sun, and dew or emotional reactions to the physical environment (e.g., witnessing lightning strike) or to the actions of others. Health may be restored through the use of herbal teas, regulated diet, compresses, baths, and massages. The treatment must be in the opposite direction of the imbalance in order

to restore equilibrium. Foods have hot and cold, heavy and light properties, such that heavy foods are eaten in the daytime to provide energy for physical labor and light foods are eaten in the evening (Miller, 2000; Nicolas et al., 2006). Moderate and chronic illnesses are often treated within the family or the naturally occurring social support system. However, infectious diseases such as AIDS and tuberculosis, as well as traumatic injuries and wounds, are considered to be best treated by Western biomedicine.

Mental health problems are often attributed to supernatural forces. Mental illness, problems in daily functioning and academic underachievement may all be seen as the consequences of a spell, a hex, or a curse transmitted by a jealous person. In such cases, people generally do not blame themselves for their illness or see themselves as defective. Indeed, the sense of self may even be enhanced as a curse is often aimed at a person deemed to be attractive, intelligent, and successful. Mental illness is also sometimes attributed to failure to please spirits (*lwa*-s, *zanj*-s, etc.), including those of deceased family members. Desrosiers and Fleurose (2002) point out that this external attribution may help recovery, in that people can call upon the *lwa*-s to intervene on their behalf to assist healing. People often rely on their inner spiritual and religious strength to deal with their problems. Mentally ill people may be seen as victims of powerful forces beyond their control and thus receive the support of the community. However, shame may be associated with the decline in functioning in severe mental illness and the family may be reluctant to acknowledge that a member is ill (Gopaul-McNicol, Benjamin-Dartigue, & Francois, 1998).

Haitian Concepts of the Person

Cultural concepts of the person can have a significant influence on help seeking behavior and models of health and illness (Kirmayer 2007). Haitian models emphasize the social and cultural embedding of the person (Farmer, 1992; Raphaël, in press). Sterlin (2006) contrasts the "anthropocentric" view of health, disease and care in the West, where the person is seen as the centre of the universe, to the "comsocentric" view in Haiti, where the person is only part of a much larger universe of spirits, ancestors and the natural world all of which must be in harmony for good health (Table 1). The Haitian concept of the person extends beyond Western individualistic notions of the self, encompass spiritual dimensions. Dayan cites a 1950s study by Haitian ethnographer Lorimer Denis, to give a typical description of personhood:

> "The *pitit bon anj* or *ti bon anj* (little good angel), the *gwo bon anj* (big good angel), and the *kò kadav* (body cadaver) constitute the three parts of individual identity in Haitian thought. […] The ti bon anj, a "guardian" and the source of consciousness, affect, and dreams, depends on the lwa for protection, for keeping the little good angel steady and bound to the

> person. The gwo bon anj, also called *lonb-kadav* (shadow-corpse), is the double of the material body […], but is understood as the shadow cast by the body on the mind. The gwo bon anj can easily detach itself from the body…When you dream you're in New York, in Paris, it's the gwo bon anj who visits these places…The three-part structure of Haitian identity is difficult to comprehend and accounts are often contradictory. What matters here is that the ti bon anj remains inseparable from all that constitutes our personality—or thinking matter—and the lwa, penetrating the ti bon anj during possession, depends on its force for support. (Dayan, 1995, p. 67-68).

Under some circumstances, it is believed that a dead person may be revived by a *bòkò* or sorcerer as a *zonbi* (zombie), who remains under the control of the *bòkò*. Deren (1983) notes that death rituals are "primarily directed against physical resurrection" (42). Because the subject of zombies has been appropriated and sensationalized by Western popular culture and films, it is important to understand the meaning of zombification in the Haitian context. The primary purpose of zombification is to obtain labor, specifically arduous agricultural labor, harkening back to Haiti's heritage of plantation slavery. The zombie is "nothing more than a body deprived of its conscious powers of cerebration… moral judgment, deliberation and self-control" (Deren, 1983, p. 42-43). Littlewood and Douyon (1997) studied three cases of purported zombification and found they involved individuals with intellectual disability or severe mental disorder who were misidentified as being a lost or deceased family member; in some cases, there were apparent personal, social or economic reasons why this misidentification took place.

Specific Mental Health Symptoms and Disorders

There are no reliable data on the prevalence of mental health problems in Haiti. The distribution of diagnoses seen at a psychiatric hospital has been estimated as follows: schizophrenia (50%), bipolar disorder with mania (30%), other psychoses (15%) and epilepsy (5%). This is not dissimilar to inpatient populations in other countries but gives no sense of the actual prevalence of these disorders in the community.

Psychosis

When people have suffered repeated psychotic episodes and their functioning is impaired, they may be labeled '*fou'* (crazy) and viewed as permanently dysfunctional. Their cognitive ability and judgment may never be trusted again, even after a long period of remission. This is a loss for the family especially in first episode psychoses where the

person had a promising future (in terms of education and career) (Desrosiers & Feurose, 2002).

For the few who have access to biomedical psychiatric care, schizophrenia is generally treated with antipsychotic drugs that eliminate the hallucinations and delusions and alleviate symptoms associated with thought disorders. The symptoms that characterize schizophrenia are based on concepts of self and non-self. In Euro-American cultures, thinking that the some entity other than the self has thoughts, feelings and goals can be seen as pathological, magical thinking or evidence of a psychotic thought disorder. However, in Haitian culture, thoughts, feelings and agency may be ascribed to invisible spirits or to the magical action of others. Diagnostic assessment, therefore, must not look only at the form, but also at the theme or the content of the behavior exhibited by the person. The same behavior characteristic of schizophrenia in Europe or North America can be representative of normal spiritual and religious beliefs in Haitian culture, for example communication with and appeasement of deceased relatives who live on as ancestral spirits (Miller, 2000).

In the Haitian context, it is particularly important to distinguish spiritual practices from psychological or psychiatric problems. If religion is ignored, misinterpretation of spiritual experiences and explanations can lead to misdiagnosis and mistreatment (Azaunce, 1995). The person who says “I see the evil spirit in my house” or “God came to me and told me to give up my job, so I did” may not be delusional or hallucinating (Gopaul-McNicol, 1997, p. 44). In religious practices that involve possession, a spirit can enter a member of the congregation to punish, reward, treat or cure another member of the congregation. As such, it is important to distinguish between negative possession experiences (by an evil spirit) which may be best dealt with by spiritual healers, and experiences of possession associated with schizophrenia, which are usually accompanied by a broader range of symptoms including blunted affect, thought disorder, deterioration in functioning, social withdrawal and poverty of speech (Azaunce, 1995).

Depression

There is a distinction between Haitians’ use of the French word ‘*dépression’* to mean discouragement, and ‘*dépression mentale’* which refers to depression as understood in Western psychiatry, usually expressed in terms of headaches, back pain or other nonspecific bodily pain (Hillel, Desrosier & Turnier, 1994). The Haitian concept of *dépression* is also usually expressed in terms of somatic symptoms: feeling empty or heavy-headed, insomnia, distractibility (i.e. “my head is not there”), fatigue, low energy and poor appetite. However, *dépression* is not considered a mental illness but a state of general debilitation due to medical conditions such as anemia and malnutrition. It may be seen as due to a Vodou curse, excessive worry, obsessive preoccupation with life

problems, or trauma. Usually, the extended family provides guidance and support for individuals experiencing *dépression* and it is rarely treated by medical professionals (Desrosiers & Fleurose, 2002).

Disorders Related to Trauma and Loss

The Haitian earthquake exposed massive segments of the Haitian population to trauma and loss. Many people lost loved ones, houses, businesses and their livelihoods. Many witnessed death and serious injury during and after the earthquake. This has been compounded by civil violence following the earthquake. These severely traumatic events will likely have an impact on the mental health of many Haitians. This may especially be the case for those with pre-existing vulnerabilities or prior exposures to trauma.

Haitian women have been recognized as more likely to develop disorders related to trauma because of their vulnerability to various types of violence, including conjugal violence, civil violence and political disorder. A study by Roseline Benjamin, a psychologist working in Port-au-Prince with victims of conjugal violence found that among 1505 women residing in 9 territorial departments "70% had been victims of violence, of which 37% was sexual violence, 33% physical violence; the offender is most often known by the victim (65%) or is the partner (36%). Many women subsequently develop symptoms of posttraumatic stress disorder (PTSD), depression, anxiety and somatic problems" (Jaimes, Lecomte & Raphael, 2008).

Another Haitian psychologist, Norah Desroches Salnave, who saw many young patients from various milieus each week in Port-au-Prince, found that about 40% had problems that may be related to violence, kidnappings, death of family members, rape and gang related violence (Jaimes, Lecomte & Raphael, 2008). The climate of terror in certain parts of the country creates chronic insecurity, aggravated by the violence experienced by children in school or at home. The effects of violence on the psychological development of children may be serious, including: delays in development, social difficulties, affective disorders, behavioral problems, or educational difficulties.

The effects of trauma are seen in local variants of disorders of anxiety, depression and PTSD but also in other emotional conflicts and idioms of distress. In writing about violence and trauma in the context of the 1991-1994 coup and the years that followed it, James found that "the most common laments among *viktim* [victims] were feelings of shame, humiliation, powerlessness, and isolation or disconnection from their families and communities" (2004, p. 137). Both men and women lamented their inability to live up to their social roles as providers for their children, and men in particular expressed rage over loss of status and property. Men's shame over their inability to act as providers often led

to the abandonment of conjugal partners and children, leading to increased vulnerability for the latter.

Aid workers may have expectations for the structure of trauma stories that do not fit with local styles of narration. James (2004) describes the structure of trauma victims' narratives in Haiti, which may not follow a linear sequence, and also addresses the concern that these accounts may sometimes be falsified or counterfeited to gain access to aid. This is part of what James labels the 'victim culture' of Haiti, which has been created by aid agencies' interventions. To some extent, the inconsistency of narratives reflects the instability of aid organizations themselves. "International and national humanitarian and development aid assemblages are frequently impermanent, accountable to their own donors and stakeholders outside the 'local' realm, and may not maintain a permanent gaze upon the suffering of aid receivers because of finite resources, especially for those who suffer under conditions of chronic insecurity" (James, 2010, 112).

James (2004) also discusses the distress associated with being unable to locate one's kin after a catastrophe. Speaking of a 60-year-old woman whose son went missing in 1992, she writes, "Her perpetual torment is not knowing if he is dead. If he is, her inability to lay his body to rest through proper funerary rites leaves her in a state of moral limbo in which she is vulnerable to haunting and persecution by the *zonbi*, an aspect of the disembodied soul of the deceased" (138).

Dissociative Phenomena and Other Folk Diagnoses

Various forms of possession trance and other dissociative phenomena may be common in Haiti, in part because of their relationship to Vodou practices (Bourguignon, 2004, p. 558). Spirit possession by Vodou spirits (*lwa-s*) can give women the power to become diagnosticians, healers, or leaders within their communities, and can have different meanings depending on the person's experience. According to Bourguignon, a striking feature of possession trance is that the spirits possessing women usually maintain the person's basic motivations; dissociation is "in the service of the self". In situations of subordination or oppression, acting out the identity of powerful spirits in trance possession provides women with an acceptable (and consciously deniable) way to express unconscious or forbidden wishes, thoughts and feelings.

Sezisman, which literally means "seized-up-ness" or "surprised-ness", is a state of paralysis usually provoked by sudden shock involving great rage, anger, indignation or sadness, or more rarely extreme happiness (Bourguignon, 1984; Nicolas, DeSilva, Grey & Gonzalez-Eastep, 2006). Frequent causes include: receiving sad news concerning a loved one, witnessing a traumatic event, seeing dead bodies, experiencing family crisis or narcissistic injuries (insults, getting fired). In brief, *sezisman* is brought on by the shock

of unexpected events or situations. Specific catalysts of *sezisman* concern woman: it is believed that delivering bad or shocking news to a pregnant woman might cause a miscarriage, premature delivery, deformation of the fetus, the woman's death or a contamination of breast milk (*let gate*, see also Farmer 1988). Great efforts are thus made to protect pregnant woman from bad news. According to Haitians, *sezisman* involves the movement of blood to the head, potentially causing loss of vision, headache, increased blood pressure, strokes, heart attacks, death (See: Laguerre 1981, 1987). The person becomes dysfunctional, disorganized and confused. Typical reactions also include being unresponsive to surroundings, weeping, refusing to speak or eat. The person can also *toufe* (suffocate). Individual reactions to the illness greatly vary and influence the duration of *sezisman*, which can last a few hours or a few days. In the case of *sezisman*, relatives will help the person to rest, drink herbal teas, apply cold compress on the person's forehead, and might recommend visiting a spiritual healer such as priest, pastor, *oungan* or *manbo*.

Endispozisyon ('indisposition') refers to spells of weakness, fainting or 'falling out' that may occur with emotional distress, especially when pain and suffering become unbearable (Philippe & Romain, 1979). In folk theory, *endispozisyon* is thought to be due to hot or bad blood. *Endispozisyon* is more common among women; for example, a woman may faint when she receives bad news about a loved one. Some bodily illnesses (e.g. menstrual cramps, pain) may also cause *endispozisyon*.

Pèdisyon refers to a culturally recognized condition in which a woman is thought to be carrying a child but the progression of the pregnancy has stopped (Coreil, Barnes-Josiah, Augustin, Cayemittes, 1996). The pregnancy begins normally but, according to folk theory, at some point the uterine blood is diverted from the fetus, which stops growing. This may occur after what biomedical practitioners would identify as a miscarriage or in situations of infertility (Murray, 1976). The condition of arrested pregnancy may persist for months or years. Although the woman believes she is still pregnant, when biomedically this is not the case, the condition differs from pseudocyesis, in that others also accept the reality of the pregnancy. *Pèdisyon* is generally a collective diagnosis reached by a woman, her family and peers, and may allow infertile women to claim the status of "being with child" or act as a way of attributing paternity to prior partners (Murray, 1976). In may also provide an explanation for female mortality associated with blood loss, tumors or otherwise unknown causes.

4. HEALTH SERVICES

Formal and Informal Resources for Mental Health

Almost half of the population of Haiti has no access to formal healthcare services (Caribbean Country Management Unit, 2006). Only 30% of healthcare facilities are public and most of them are in urban areas. In rural areas, 70% of health services are provided by nongovernmental organizations and include mainly primary health care. A number of hospitals are run by private foundations (Caribbean Country Management Unit, 2006). Most people in Haiti value professional biomedical services; however, they are not able to access this type of care because of structural barriers such as cost, distance and location.

The health care system in Haiti can be divided into four sectors:

1. Public institutions administrated by the Ministry of Public Health and Population (MSPP);
2. The private nonprofit sector, comprised of NGOs and religious organizations;
3. The mixed nonprofit sector, where staff are paid by the government but management is carried out by the private sector;
4. The private for-profit sector, which includes physicians, dentists, nurses and other specialists working in private practice or in clinics in urban centers.

The MSPP is responsible for the health of the population, delivery of services, policy-making and management of the health budget, which makes up 7% of total public spending (PAHO/WHO 2003). The public sector comprises about 36% of health facilities. Most institutions are autonomous; there are no networks of services. The private sector is estimated to provide one-third of the medical care in Haiti. According to a PAHO/WHO report (2003), in 2001, there were about 2,500 physicians in Haiti, of whom 88% were practicing in the country's *Ouest* [West] department, an area which includes Port-au-Prince.

Mental health, as defined by Western psychiatry and psychology, has not been a priority for the government. In the absence of a mental health policy, there has been no real planning of services. The mental health system has very few professionals. A 2003 PAHO/WHO report counted 10 psychiatrists and 9 psychiatric nurses working in the public sector. Moreover, these professionals mostly work in Port-au-Prince, to which Haitians must travel to receive mental health services. There are two psychiatric hospitals in Port-au-Prince, one of which was already in a dilapidated state before the 2010 earthquake. The availability of follow-up community treatments was very limited. At the country's second largest hospital, l'Hôpital Universitaire Justinien in the city of Cap-

Haïtien, psychiatric services are limited to a monthly visit by a psychiatrist from Port-au-Prince. No other psychiatrists offer services in Northern Haiti. Mental health services have, unsurprisingly, received little funding by the government.

- Given this longstanding lack of formal health care resources, Haitians have learned to deal with their mental health problems through deployment of various strategies common to resource-poor regions. As explained previously, a very large number of Haitians make use of traditional practitioners or religious healers when face with mental health problems. There are several types of traditional healers available in Haiti who may treat specific illnesses or address general well-being (Miller, 2000):

- *doktè fèy*, *medsen fèy* (leaf doctor) or herbalists often treat illnesses such as colds, worms, diarrhea, and stomach ache;

- *oungan* (Vodou priest) or *manbo* (Vodou priestess) treat many conditions;

- *doktè zo* (bone setters) treat conditions such as broken bones, musculoskeletal or joint discomfort;

- *pikirist* (injectionists) administer parenteral preparations of herbal or Western medicine);

- *fanm saj* (midwives) perinatal and natal care.

In recent years, Haitians have mobilized a network of community resources to sensitize the population to social issues related to various problems such as violence against women and children's rights. These grassroots organizations also serve as self-help and support groups for people facing severe life events and ongoing stress. Self-help illness support groups have also emerged, but characteristically, these tend to focus not on the illness but on religion and spirituality, artistic and expressive activities and ways of generating income to better support participants and their families.

Birth. In rural areas midwives (called *matwòn* or *fanm saj*) deliver babies and perform most prenatal and postpartum care for both mother and child. Immunizations are not easily available to rural residents. Mother and child spend the first month or 40 days in seclusion, during which time the circle of women close to her provide for her needs. This period of seclusion stems from a common belief that maternal illness can be caused by rapid and excessive chilling of the body. If the mother becomes chilled, it is believed that the disequilibrium may be passed on to the baby through the nursing milk and may cause tetanus and diarrhea. The mother must also avoid *move san* ('bad blood', distress caused by a fright or exposure to negative emotions) as this can cause *lèt gate* ('spoiled milk') as

well as diarrhea, skin rashes and failure to thrive in the infant. Breast milk can become too thick and can give the mother headache and cause depression in the mother and impetigo in the infant. Farmer describes *move san* as "illness caused by malignant emotions-anger born of interpersonal strife, shock, grief, chronic worry, and other affects perceived as potentially harmful" (1988, 63). The *move san* syndrome is also believed to be capable of progressing to AIDS (Farmer, 1988, Miller, 2000).

***Death*.** Haitians usually approach death as a natural part of cycle of life. Haitians hold their deceased family members in high regard and perform elaborate, costly and extended funeral rituals to assure the goodwill of the deceased. Deceased family members are still considered to be part of the family; they advise and help their descendents through dreams (Miller, 2000). Dayan (1995) writes, "If the disposal of dead slaves was a careless deed that marked irrevocable inhumanity, funeral rites in independent Haiti became central to both the living and the dead. The deceased do not worry about their future life but fear that they might not be properly served by the living" (p. 264). The issue of proper death rites and burial is particularly important in the wake of the earthquake. Many people have not had the opportunity to find and bury their lost loved ones or had to abandon them, or see them buried in a mass grave with no ceremonies. As a result, there may be an increase in ambiguity and uncertainty over the fate of the dead, with the risk of nightmares, worries and moral concerns when thinking about the dead.

Help-seeking and Service Utilization

Regardless of the type of illness, family members are usually the first to be consulted regarding treatment and advice. Haitians may not accept psychotherapy because solving personal problems is viewed as a family or religious matter (Gopaul-McNicol, Benjamin-Dartigue, & Francois, 1998). Instead, they readily consult elders and religious leaders in the community. Churches tend to confirm the belief that God will solve the problem. Many Haitians believe that God is more powerful than any other force, including as Vodou *lwa-s* or medical treatment (Desrosiers & Fleurose, 2002; Miller, 2000).

Haitians from the lower class will generally seek help for a mental problem from an *oungan* (a male Vodou priest). They may visit a mental health professional if a visit to an *oungan* has been unsuccessful. Some may simultaneously use both an *oungan* and a mental health professional. Upper and middle class Haitians are more likely to seek psychiatric care before consulting an *oungan* as they adhere to the biomedical model of mental illness and biopsychosocial forms of treatment. While Orthodox Roman Catholics and fundamentalist Protestants will generally not consult *oungan*, they will visit a *doktè fey* (herbalist) and will often go to church and pray. This gives them a sense of control over a situation where they may feel powerless. Many patients are averse to hospitals because patients often arrive in advanced states of illness and subsequently die in

hospital. This contributes to a commonly held belief that "those who go to the hospital die" (Deren, 1983, 168).

Based on ethnographic and survey data from a rural area in Haiti, Coreil (1983) described the professional (formal) and folk (informal) spheres of health care in Haiti. Dispensaries (religious health care facilities) and herbalists were by far the most common choice for treatment (80% of all consultations), they were less expensive and more easily available, practitioners often visiting patients in their homes. Hospital clinics and other types of healers were physically less accessible and their treatments more expensive. Patients therefore resorted to them less frequently (only 6% and 5% of consultations, respectively) to treat more uncommon and severe illnesses.

Brodwin (1997) studied biomedical health services in a small village in southern Haiti, where a public clinic provided primary health care, through a "Rural Health Care Delivery System" that emphasized "the equitable distribution of resources and the cost-effective provision of preventive care" (p. 75). He describes the interactions between staff and patients: "most people do not come prepared with a story of their illness to tell the dispensary staff but instead expect staff to take the initiative and give them a physical exam and prescription for medication" (77). Brodwin goes on to describe the teasing and chastising of patients by nurses, arguing that this behavior is indicative of codes of deference that are enforced by institutions throughout the village.

Treatment Expectations

Haitians expect healthcare professionals to be engaging and active in resolving issues. In general, Haitians do not like to expose their intimate or domestic problems to strangers or professionals. Many are shocked by the ways that some Euro-Americans discuss their private difficulties in public or with complete strangers. For some Haitians, mental health problems are considered taboo, shameful, and should be hidden from people outside of the family. Any initial psychological assessment should explain the goals and process of treatment and focus on establishing trust. Empathic listening and culturally consonant explanations will help show that the helper is credible, trustworthy and potentially effective.

Most Haitians do not use Western psychological language to explain their symptoms and feelings. Writing for U.S. practitioners, Desrosiers and Fleurose (2002) note that Haitians tend to tell their story in minute detail in order to provide the circumstances surrounding an event. They point out the importance for the clinician to remember some of the details and refer to them during the session as a sign of interest and caring. Haitian patients may expect a concrete plan of action at the end of any encounter. Neutrality and lack of feedback may be seen as a waste of their time. Concrete action could include assisting

with practical needs for food and clothing (Desrosiers & Fleurose, 2002; Gopaul-McNicol, Benjamin-Dartigue, & Francois, 1998). Once trust is established, Haitians may expect the mental health professional to be a respected authority figure and expert who can solve problems quickly.

5. CONCLUSION

Having faced much historical injustice and the continuous structural violence of global economic policies, many Haitians have learned to maintain hope in the face of severe adversity. Many believe that the future will be better and that education will help them get out of poverty. Religion contributes to their hope and provides them with a sense of control over their destiny. To build on this indigenous resourcefulness, helpers should be prepared to learn from their clients.

Clinicians should be aware of their own beliefs and attitudes about illness and toward Haitian culture in order to understand how this may impact on their relationships with patients. They need to acknowledge the medical diversity that exists in Haiti. Patients use multiple explanatory models and sources of help. Clinicians must avoid an ‘either/or’ stance that forces patients to choose between biomedicine and traditional healing. They must assess the client’s and the family’s understanding of the illness. Attention should be given to spiritual understandings of the illness and sensitive clinicians must work collaboratively with the family and the community.

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