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In the Midst of It All: a Qualitative Study of the Everyday Life of Haitians during an Ongoing Cholera Epidemic

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IN THE MIDST OF IT ALL: A QUALITATIVE STUDY OF THE EVERYDAY LIFE OF HAITIANS DURING AN ONGOING CHOLERA EPIDEMIC

By
Kapriskie Seide

A THESIS

Submitted to the Faculty of the University of Miami in partial fulfillment of the requirements for the degree of Master of Arts

Coral Gables, Florida
December 2016
A thesis submitted in partial fulfillment of the requirements for the degree of Master of Arts

IN THE MIDST OF IT ALL: A QUALITATIVE STUDY OF THE EVERYDAY LIFE OF HAITIANS DURING AN ONGOING CHOLERA EPIDEMIC

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In The Midst Of It All: A Qualitative Study Of The Everyday Life Of Haitians During An Ongoing Cholera Epidemic.

Abstract of a thesis at the University of Miami.

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Studies focusing the cholera epidemic in Haiti seldom examine the social dimension of this waterborne disease epidemic from the perspective of the population. Further, the social contexts within which people’s behaviors, practices, and meanings are formed is undervalued. As the number of cholera cases continue to vacillate over the years, understanding Haitians’ behaviors in this conjuncture is a sine qua non since the control and eradication of any waterborne disease epidemic requires a biosocial approach.

This study addresses this gap.

From a symbolic interactionist perspective, using a constructivist grounded theory methodology, this study examined the extent to which the epidemic changed the everyday life of Haitians since its onset in 2010 with a focus on the processes by which people are adapting to cholera related disruptions. Data were collected through interviewing thirty Haitians living in Port-au-Prince, Haiti.

The theory developed explains the ways in which individuals navigate changing social and epidemiological contexts amidst the ongoing cholera epidemic. Results indicate that changes in people’s behaviors and practices are linked to their understanding of the epidemic’s life cycle, structural factors (i.e. provision of public services), their perception
of the disease, and their concern with societal blame. Lastly, economic resources are primary factors that mitigate risks of cholera exposure. Having a reliable source of income and being integrated in cohesive social networks were key means of adaptation that allowed people to follow cholera prevention guidelines despite of inadequate water and sanitation infrastructures citywide.
DEDICATION

I dedicate this work to the orphans of the cholera epidemic and the 2010 earthquake in Haiti.
ACKNOWLEDGEMENT

The completion of this thesis is made possible with the help and support of a myriad of people. To everyone who helped me either directly or indirectly during this process: thank you.

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Chapter 1: Introduction

This study grew out of a research project on the social and subjective meaning of Ebola (Belgrave, Pierre Louis, and Seide 2014). For that work, I conducted in-depth interviews with four Haitians on their perception and understanding of the Ebola epidemic. At the end of one interview, a participant suggested that I investigate the cholera epidemic in Haiti. During the process of coding these interviews, participants drew parallels between the Ebola epidemic in Africa and the cholera epidemic in Haiti. After digging in the literature at the time, I noticed only two qualitative study on the cholera epidemic in Haiti since the onset of the outbreak in 2010 (Grimaud and Legagneur 2011; Williams et al. 2012). As the control of a waterborne disease like cholera is contingent on understanding individuals’ decisions and behaviors in the midst of the epidemic and their impacts on the continual transmission of the pathogen (Whiteford 2004), inquiries pertaining to the social dimension of that epidemic became a sine qua non.

Less than one year after the devastating earthquake of 2010, Haiti faced a cholera outbreak that has infected 769,089 people and left 9,202 dead (Ministère de la Santé Publique et de la Population 2016). To put the situation into perspective, the cases reported would have involved more than 90% of the 2010 population of the State of Alaska, or the entire population of any one of the states of Wyoming, Vermont or North Dakota (US Census 2010). Although all of these states are among the least populated in the United Stated, the superficiality of each of them surpasses that of the Haiti.

In 2011, an independent panel of experts, convened by the UN state secretary, officially determined the cause of the outbreak and identified an upstream region of the
Artibonite River, Haiti’s largest interstate river, as the point source of the outbreak (Lantagne et al. 2013). Based on the findings of the epidemiological investigation, the river was contaminated with cholera bacteria through a leak in the sewage system of a UN peacemaker camp that poured directly into a tributary the Artibonite River. Since the pathogen proliferated and people living in regions drained by the river system depend on it to subsist, cholera incidence rates erupted, rapidly spreading across the country (UN 2014). Within a one-week period, 4,722 hospitalizations and 303 deaths were reported (Chery, Dodard and Fournier 2012). This outbreak escalated to a nationwide epidemic within a month, making it the worst outbreak to day (CDC 2011). A myriad of opportunistic conditions facilitated the proliferation of the cholera bacteria: the contaminated river being a major source of water supply; poor water sanitation; execrable infrastructure; internal migration of people and lack of reinforcement of preventive measures (Lantagne et al. 2013). The epidemic compounded the burdens of the earthquake and that of hurricane Tomas that followed close on the heels of the cholera outbreak.

Based on latest cholera surveillance data, the number of cholera attributed deaths and incidence rates have significantly decreased since 2010. The number of reported cases had a 90% decreased from its peak in 2011 with over 350,000 reported cases to 27,388 suspected cholera cases in 2014 (UN 2015). Efforts by national and international coalitions to control the impact of this health crisis are constantly challenged by a variety of issues: weather conditions, poor water and sanitation infrastructure, a fragile health care system, and a lack of resources to fund health interventions and preparedness (Andrews and Basu 2011; Tappero and Tauxe 2011; Eisenberg, Kujbida, Tuite et al.
The prevalence of cholera and case fatality rates escalate at different periods - slower during dry seasons (MSPP 2016). As of February 2016, there are already 7,782 cases of cholera and 96 deaths reported (MSPP 2016). According to the UN Senior Coordinator for the Response to Cholera in Haiti, the cholera outbreak is controlled; however, the eradication of the cholera epidemic is contingent on the improvement of the health, water and sanitation infrastructure which have not been prioritized (UN 2015).

The impacts of any epidemic in general stretch far beyond the health of affected individuals; they permeate social and the economic sectors (WHO 2016). In developing countries, studies have shown how the education sector for instance, vital to a society’s development, can be destabilized by a hemorrhaging loss of talents affected by an infectious disease (Fonkwo 2008). The negative impact of major infectious diseases on a specific country could reach other countries through a ripple effect of disruptions that can only be decelerated through international coalitions (Fonkwo 2008). These disruptions could form an amalgam of visible and invisible issues which cannot always be empirically delineated. In fact, health experts can prioritize the control of an epidemic to the extent of missing the silent emergence of an invisible outbreak of emotional distress in its midst (Hougendobler 2015). This situation could give impetus to a “medical version of the Hobbesian nightmare - the war of all against all” (Strong 1990, p 258) or a “plague mentality” (Schafer 1991, p 6) to designate attitudes, such as victim blaming, adopted by the population living in the health crisis. When it comes to the cholera epidemic in Haiti, the nature of the reality in which Haitians are living becomes a glaring question that the literature on the cholera epidemic in Haiti has yet to answer as the pathology of the
disease is almost exclusively explored within a positivist framework (Frerichs Keim, Barrais and Piarroux 2012; Orata, Keim and Boucher 2014). The findings of these studies shed light on certain aspects of the epidemic’s dynamics, the disease’s mechanisms of spread and transmission which guided the implementation of relevant public health interventions to decelerate the spread of cholera related losses. In fact, this outbreak is “the best documented cholera outbreak in modern public health” (CDC 2011). Nevertheless, six years since the onset of the outbreak, the country still struggles to combat this complex public health issue which needs to be addressed at multiple levels (WHO 2016). Additionally, the control of a waterborne disease like cholera “depends on understand of human decisions and behaviors surrounding the continual transmission of the bacterium” (Whiteford 2004). For a country with no previous history of cholera outbreaks (Tauxe et al. 1994; Jenson 2011), questions pertaining to the social dimension of the epidemic become glaring as the epidemic is still not under complete control (MSPP 2012). Researchers could gain additional insights on the cholera epidemic by exploring the social reality in which this epidemic is evolving using another approach. Such an approach could be instrumental in the comprehensive understanding of this health conjuncture and facilitate the appropriate conceptualization of other involved factors. As Kleinman, Eisenberg and Good (1978:251) proposed: “Only if we are able to conceptualize those problems in terms appropriate to their analysis are we likely to make progress toward their resolution.”

In light of this gap, using symbolic interactionist theoretical orientation and a constructivist grounded theory methodology, I aimed to examine the impact of the epidemic on people’s lives focusing on their social reality and their adaptation process. I
interviewed 30 Haitians, between the ages of 18 and 60, who reside in Port-au-Prince to address the following research questions:

1. To what extent has the cholera epidemic changed the daily lives of Haitians living in the country?
2. What kind of reality are they living in?
3. How are Haitians mending their reality following the various disruptions caused by the epidemic?

This approach allowed for the exploration of the health crisis as it is interpreted and understood by the Haitian population within their meaning framework. Since the study focuses on people who live in Port-au-Prince in the midst of an ongoing cholera epidemic, a constructivist grounded theory allows for a personalized theoretical understanding constructed by the participants themselves with the researcher (Creswell 2013; Charmaz 2014). This study provides an opportunity to understand the way Haitians construct and reshape their realities in the face of this epidemic.
Chapter 2: Contextualization and Research Problematic

This chapter presents a review of empirical research relevant to this master’s thesis. First, I set up the context of the research problematic by providing an overview of key elements: The Artibonite River, the water and sanitation infrastructure in Haiti, and cholera. Second, I provide a background to the topic of cholera in Haiti in order to situate this current project.

Artibonite River

The Artibonite River is the longest river of the entire island of Hispaniola (Britannica 2015). Its sources are located at the central mountains the Dominican Republic, and it stretches across Haiti all the way to the Gulf of Gonâve – connected to the Atlantic Ocean. The river is an integral part of many aspects of the Haitian population’s livelihood including but not limited to agriculture, and everyday use.

Figure 1- Map of the Artibonite River
Water, Sanitation and Hygiene (WASH) Infrastructure

In the Western Hemisphere, Haiti has the lowest rates of access to improved water and sanitation infrastructure (Gelting, Bliss, Patrick, Lockhart et al. 2013). The water, sanitation, hygiene (WASH) sector has been historically unfunded and underdeveloped (MSPP 2013). After the earthquake, more than 182,000 people moved from Port-au-Prince to internal displacement camps located in rural regions for shelter. This massive internal migration deteriorated the living conditions of many rural communities which were not equipped to meet the sanitation and water demands from the start (Farmer, Almazor, Bahnsen, Barry, Bazile, et al. 2011; Walton and Ivers 2011; Tappero and Tauxe 2011).

The earthquake and the cholera outbreak exacerbated poor living conditions and exposed systemic infrastructural flaws laying at the core of these execrable conditions (MSPP 2013). Haiti’s Ministry of Public Health and Population, with the support of other national and international health organizations, coordinated public health responses to the cholera outbreak (CDC 2011). They launched a surveillance system to continuously assess and monitor the impact of the epidemic throughout the country (Barzilay, Schaad, Magloire, Mung et al. 2013). The coalition also implemented multiple interventions in tandem with community education to contain the spread of the outbreak and directed their efforts towards short term WASH related cholera responses. Short term responses included providing healthcare services, improving access to potable water and sanitation, increasing the chlorination of water supplies in various communities, and disseminating cholera prevention and hygiene promotion materials (MSPP 2013). As evidenced by the latest surveillance data, overall, cholera mortality and morbidity rates have significantly
degrees since the onset of the cholera outbreak; more remains to be done as the prevalence of cholera and case fatality rates continue to peak at different periods (MSPP 2016). This pattern is attributed to various infrastructural catalysts such as poor infrastructure, a lack of resources for the funding of intervention and preparedness, and a fragile health care system (Mazzeo and Chierici 2013; UN 2014; UN 2015). Experts postulated that the long term control of this health crisis’ impact is contingent on the improvement of the water and sanitation infrastructure as previously seen in other countries that successfully eradicated a cholera epidemic (Waldman, Mintz, and Papowitz 2013).

**Cholera**

Cholera is a dehydrating diarrheal disease caused by the *Vibrio cholerae* bacterium, or V. cholerae, which thrives in warm waters with low salinity (Levy 2015). These bacteria secrete a toxin that causes the small intestine to release water. The early symptoms of cholera include white rice water stool with muscle cramps, thirst, and loss of skin elasticity. Without any interventions, the symptoms can rapidly escalate to dehydration, renal failure, coma and death (CDC 2014). In an immunologically naïve population, adults and children are equally vulnerable to cholera and can die within hours due to late detection or delayed treatments following a diagnosis (Farmer et al. 2010). Immediate treatment consists of oral rehydration therapy, IV transfusion, and the administration of antibiotic. The latter treatment should be used with caution to avoid bacterial resistance.
Cholera is acquired from ingesting water and food contaminated by the feces of infected individuals (CDC 2014). There are different types (or serogroups) of V. cholerae, and only two can cause a cholera epidemic: serogroup O1 and serogroup O139 (CDC 2012). The V. cholerae O1 causes the majority of reported outbreaks worldwide (WHO 2016). Additionally, it is endemic in the Indian subcontinent. *Vibrio Cholerae* serogroup O1 itself is divided into two biotypes: classical and El Tor. The UN independent panel identified the V. Cholerae O1 as the cause of the cholera outbreak in Haiti. This type of V. Cholerae O1 share certain genetic characteristics with the South Asian V. Cholerae O1. The findings of the panel’s molecular analysis confirmed the hypothesis that the disease was introduced in Haiti (Lantagne et al. 2013). There are no cures for cholera. Although oral vaccinations are available for immunization, the containment of this infectious disease is heavily dependent on access to clean water, good sanitation, health education, and the timely administration of treatment. Overcrowded areas and urban areas with poor infrastructure are breeding bed for a cholera outbreak. The disease could also be transmitted from person to person, and care givers are particularly at risk of contracting it without adhering to strict guidelines such as frequent washing of hands and proper disposal of contaminated objects and human waste (CDC 2014). Despite medical advancements, this infectious disease is a public health issue in many developing countries and an indicator of social underdevelopment (WHO 2016). Researchers have estimated that there are roughly 1.4 to 4.3 million cholera cases, and 28, 000 to 142, 000 cholera attributed deaths per year worldwide (Ali,
Lopez, You, et al. 2012). In 2014, 55% of the reported cholera cases were from Africa, 30% from Asia and 15% from the Americas (WHO 2016)\footnote{1989 – 2014 Cholera Cases Graph: http://www.who.int/gho/epidemic_diseases/cholera/cholera_005.jpg?ua=1.}

**Literature Review**

The troops of UN soldiers deployed in Haiti in early October 2010, at the start of the rainy season, were trained in Kathmandu, the capital of Nepal, which was dealing with a cholera outbreak at the time (Orata, Keim and Boucher 2014). Since none of the soldiers exhibited symptoms related to the infection, they were not tested for cholera prior to their deployment (BBC 2010). Shortly after their arrival in Haiti, the first case of cholera was reported (Lantagne at al. 2013). Journalists reported a situation in which pipes from a UN camp leaked fecal waste into the river (Katz 2010; Aljazeera 2010). These claims caused social and political tensions in the country for weeks. The lack of empirical evidence and the preexistence of vitriol toward the non-governmental organization, which had been committing a slew of unpunished human rights violations, undermined the validity of these allegations then. At the onset of the cholera outbreak, there was no consensus over the etiology of the infectious disease on the Western part of the island of Hispaniola. Some scientists hypothesized that the disease was introduced into the country by carriers of the pathogenic *V. cholerae*. Others postulated that the earthquake triggered the proliferation of the *Vibrio cholera* bacteria which naturally existed in the country’s environment and mutated into a virulent pathogen (Orata, Keim and Boucher 2014). In
their extensive textual analysis of 19th century medical and lay sources, Jenson et al. (2011) found no evidence of cholera cases in Haiti in the three major documented pandemics that involved the Caribbean. Additionally, government records in Haiti from the 19th century indicated that Haitian officials were aware of the spread of the infectious disease well before it reached the Caribbean and implemented ad hoc policies to prevent the introduction of the cholera bacterium in the country by quarantining ships coming from affected regions. Unlike other surrounding cholera stricken islands, where the disease was imported by human activity linked to slavery (migration of slaves and colonial soldiers), Haiti benefited from the isolating effects of its implemented Monroe doctrine-like foreign policies following its independence in 1804. Similar findings were previously reported on the absence of cholera in Haiti (Kiple 1985).

Early independent investigations matched the bacterium in Haiti to the variant\(^2\) of V. Cholerae endemic in South Asia (Chin et al. 2010, Piarroux, Barrais, Foucher et al. 2010). These findings exacerbated socio-political tensions in the country and ultimately gave impetus to violent anti-UN protests (Fraser 2010). These clashes resulted in the death of several demonstrators and cases of injuries on both sides. The Haitian population’s claims over the cause of the 2010 cholera outbreak grew into strong feelings of distrust to the extent of attributing the health crisis to a conspiracy involving the deliberate importation of the cholera bacteria into the country to annihilate them. Many Haitians feared the world was ending. Some stopped eating to avoid contaminated food and tied clothes around their stomachs to quell hunger pangs (Kean 2014: 1267). People

\(^2\) Biological terminology: strain.
were dying at their homes, hospitals’ gates, or in route to the nearest health centers (Walton and Ivers 2011). The start of what could be described as a cycle of accusation (Farmer 1992) posed a threat to any interventions’ possible progress given the Haitian community’s history of being stigmatized and blamed for other epidemics like AIDS, during which the virus was described as a Haitian virus brought to the U.S. homosexual population.

Historically, cholera had been a stigmatizing disease associated with filth and poverty (Talavera and Perez 2009) and the epidemic brought back that stigma against Haitians (Hamlin 2012). The most effective strategy to contain the epidemic was to integrate prevention measures and care because of the country’s profile where many urban and rural regions are underserved and many people struggle financially (Ivers, Farmer, Almazor, and Léandre 2010). In order to facilitate the effectiveness of public health responses to the outbreak, it became essential to appease the population by determining the source of the cholera outbreak (Piarroux et al. 2010).

Numerous independent epidemiological investigations, and laboratory analyses focused on the cholera outbreak since its onset in 2010 (Frerichs et al. 2012; Orata, Keim and Boucher 2014). After the publication of several reports with contrasting evidence, the UN state secretary convened an independent panel of experts to definitively determine the source of the cholera outbreak in Haiti (Lantagne et al. 2013). The panel consisted of four experts: a microbiologist, an epidemiologist, a cholera expert, and a water and sanitation expert. They discovered that the type of V. Cholerae bacteria present in the country was pathogenic and quite similar to the variant of V. cholerae O1 in South Asia. They identified Mirebalais, an upstream region west of the Artibonite River, the location
of the UN camp site of the Nepalese soldiers, as the starting point of the outbreak. The evidence indicated that the cholera bacterium was introduced to Haiti’s water system through the UN’s improper disposal of human waste in a septic pit nearby the Artibonite River. During the rain fall, the tributary would overflow and spill into the river’s side stream. Since the river is the main water supply and an integral of everyday activities, cholera incidence rates erupted, and spread along the river. The exact origin of the bacteria in question could not be determined by the independent panel since no samples from the Nepalese soldiers were made available for a comparative DNA analysis of the V. cholerae bacteria.

Despite the overwhelming evidence, legal claims of Haitian victims against the UN fell into deaf ears. In fact, a U.S. judge granted absolute immunity to the humanitarian organization during the fall of 2014 (Ingram and Charboneau 2015). The UN defense lawyers argued that allowing lawsuits could expose the UN’s flank to an onslaught of litigation that could prevent the organization from pursuing its humanitarian deeds worldwide.

MSPP, in concert with non-government and international organizations, responded to the epidemic by launching awareness campaigns and intervention programs (Farmer et al. 2011). In Haiti, case-fatality rates have dropped to 0.75% in 2015 from 2.43% at the outset of the epidemic (MSPP 2016); incidence has also declined to 3.9 per 1000 habitants in 2015 from 18.36 per 1000 habitants in 2010 across the country. The impact of the epidemic is not evenly distributed across the country. Epidemiological indicators experience seasonal peaks with increases of cholera cases during the rainy season (MSPP 2016; Farmer et al. 2011). This situation underscores the need for more long term
responses to the cholera epidemic, which rest on the improvement of WASH infrastructures (Waldman, Mintz, and Papowitz 2013).

Intervention programs played an important role in short term responses to the cholera epidemic (PAHO 2013), but their effectiveness and limitations are not explicitly shown. There is a lack of quality studies with well-defined health outcomes that show the effectiveness of many public health interventions (Taylor, Kahawita, Cairncross et al. 2015). Moreover, intervention approaches vary across organizations. The Haitian government and certain aid organizations do not see eye to eye when it comes to the most suitable approach to address the need for clean water and sanitation during the cholera epidemic (Kean 2014). The former believe that water and sanitation needs should be addressed in tandem. The Haitian government, while welcoming the improvement of water initiatives for communities, maintains that sanitations matters, such as the construction of latrines, should be left to the responsibility of the individual to “promote personal responsibility” (p. 1267).

Researchers pointed out that intervention programs are not applicable to all populations (Contzen, Meili and Mosler 2015). The current one-size-fits-all framework of handwashing campaigns for instance, needs to be more theoretically grounded and should consider attitude and norms in their approaches to improve their impacts. There is a need for more studies of the different cultures and contexts of countries dealing with a diarrheal disease epidemic. Recognizing that reality is different within and across populations, and that it is socially constructed is critical to understand the context in which the target population lives, their experiences and their behaviors. This could be quite a challenging task to undertake within a positivistic framework that assumes that
reality is uniform and exists independently from the individual. Quantitative method, which focuses on measuring or predicting relationships, could focus on constructs that that are not necessarily relevant to the population of interest. If a problem is not appropriately conceptualized, then little can be said regarding the validity of its potential solutions (Kleinman 1978). Researchers could gain more insights on the cholera epidemic if they take the reality in which this epidemic is evolving into account.

Findings from the plethora of epidemiological and molecular genetic investigations have been instrumental in the assessment, the monitoring and the short term containment of the cholera epidemic in Haiti (Frerichs et al. 2012). When it comes to the social dimension of the cholera epidemic in Haiti, the literature has yet to provide more answers. Grimaud and Legagneur (2011) analyzed people’s perceptions of cholera in Haiti and found that in addition to fearing the disease, many community members were very suspicious of aid organizations because of the political undertone linked to the etiology of the illness. By the means of psycho-social group discussions, they found that the perceptions and beliefs of community members played a role in their rejection of humanitarian interventions. Grimaud and Legagneur (2011) suggested that understanding communities’ dynamics and their dominant perceptions, could facilitate the establishment of a rapport with the populations which could then bolster the effectiveness of public health responses to the outbreak.

Williams et al. (2015) examined behaviors, perceptions toward water and hygienic practices in rural areas in Haiti by conducting focus groups. They found out about the extent of the community members’ knowledge of health information disseminated by behavior change intervention programs, their practices, and their needs. For instance,
they discovered that many community members were more likely to treat water during rainy seasons because of the belief that cholera is more prevalent during that period. They also reported significant comments from participants regarding water treatments. Some stated that they did not treat their water because “Mikob pa touye ayisyen”\(^3\) (p. 6). Grimaud and Legagneur (2011) also reported this adage in their conducted group discussions about local beliefs and perceptions. Williams et al. (2012) underscored translation as one of their biggest limitations. During their analysis, certain responses were even discarded because they indicated that the questions were not well understood by participants.

Both studies provided important answers about the perceptions and beliefs in Haitian communities regarding cholera that have important public health implications; however, they remained exterior to the participants’ reality. It is worth noting that the information shared by the participants does not carry any inherent significance. What do they mean by “the microbe that can kill Haitians is not yet existing”? Williams and colleagues (2012) reported that as a belief that Haitians are “so used to microbes, and have become so resistant, that no microbes can kill them” (p. 27). Grimaud and Legagneur (2011) explained it as a way for the Haitian participants to convey the disbelief that unsafe water poses a threat to their health. Both interpretations are relevant; however, they vary slightly and do not necessarily coincide with what the participants meant, since each group of individuals has a different meaning framework that imbues a distinct significance to their understanding of the world. Additionally, the primary goal of these

\(^{3}\) Williams et al. (2015)’s translation: the microbe that can kill Haitians is not yet existing.
research projects was to help organizations improve the planning and implementation of interventions, neither to understand the reality within which these perceptions and beliefs are being constructed nor to explore the social context and experience of the Haitians living in the midst of an epidemic.

Considering the visible and possible invisible sequelae of the cholera epidemic, researchers could gain even more insight on the health crisis if they attempt to understand the social reality in which the epidemic is evolving as well.

**Problem Statement and Research Questions**

Previous studies have examined perceptions and behaviors in some Haitian communities vis-à-vis the cholera epidemic to facilitate the implementation of public health interventions (Grimaud and Legagneur 2011; Williams et al. 2015). Unlike other studies, I investigate the social reality in which the epidemic and the actors who construct these previously explored perceptions and behaviors are evolving. I pay attention to the impact of the epidemic on people’s lives with a focus on their social reality and the mechanism of adaption they utilize. I use a symbolic interactionist theoretical orientation and a constructionist methodology to address the following research questions related to the social reality of individuals living in the midst of a cholera epidemic in Haiti:

1. To what extent has the cholera epidemic changed the daily lives of Haitians living in the country?

2. What kind of reality are they living in?
3. How are Haitians mending their reality following the various disruptions caused by the epidemic?
Chapter 3: Theory

This chapter presents the theoretical framework for this qualitative study. It focuses on two sociological theories that will guide this research’s methodology. It first begins with a discussion of symbolic interactionism then the social construction of reality. After these discussions, this section will transition to the chapter on methods by explaining its link to the theory. I selected these theories for two reasons. First, they represent a range of sociological perspectives that offer a different ontological and epistemological orientation from the positivist approach as well as a different approach to explore the matter being studied. Second, these theories present an avenue for sociological ideas to add to the understanding of this epidemic.

Symbolic Interactionism

The origins of the symbolic interactionism perspective can be traced to the works of George Herbert Mead. This perspective offers a theoretical framework for “viewing social realities rather than a definitive explanatory theory that specifies variables and predicts outcome” (Charmaz and Belgrave 2015, p 13). Symbolic interactionism considers how society is constructed and re-constructed through individuals’ social interaction. From this perspective, the processes involved in re-constructing reality and navigating everyday life are dynamic and interactive. These social interactions depend on spoken and unspoken symbols; language and meaning that are shared among individuals. In Mead’s view (1934), an individual is an abstraction from a social group and society is not simply a group of interrelated individuals. He argued that the behaviors of individuals can be understood only in terms of the behaviors of the social group of which they
members (Mead 1934:6); their individual acts implicate their other group members. The concept of reality to which I am referring in this project is in diapason with Mead’s (1938) view of reality that differs from that of positivism; it is a social construct. Reality here is the outcome of the dynamic interrelation of individuals and environment; it is not exterior to the individuals. Concepts of society, culture, mind or self exist because of human interactions and are perpetuated by symbolic interactions. In this sense then, the perceptions of the individuals do not occur exclusively in them, but between them; it is a relation between the said individuals and their environment.

The starting point for the quest of meeting this study’s objective through a symbolic interactionist approach is with Blumer's work. Blumer has interpreted the works of Mead and elaborated the Chicago school tradition of symbolic interactionism. Blumer (1969:2) outlined three premises of symbolic interaction which offer an insight into this study’s focus. The historical underpinnings of these three premises can be found in the works of G. H. Mead, C. H. Cooley, and W. I. Thomas.

First, Blumer (1969) suggests that people act toward other people and things in accordance to the meanings they assign to them. This premise is particularly salient since I am attempting to understand the effects of the epidemic on the Haitian population. Researchers are more likely to get to the core of the target population’s experiences and behaviors if they recognize that "the meanings that things have for human beings are central in their own right" (Blumer 1969, p. 3).

Blumer's second premise, which adds to the first one, states that the meaning of things stems from social interactions. The meaning of things such as running water, or the
role of the UN are not intrinsic; instead, through social interactions, the population learn what these things are and how to respond to them. This premise tells us that there is nothing innate about how people respond to certain situations or how a society is constructed. The final premise states that meanings are used and changed through an interpretive process.

Later on, Charmaz (1980) added to Blumer’s premises. First, she argues that meanings are interpreted through language and communication that are shared among individuals. Second, the mediation of meaning in social interaction is distinguished by the relationship between gestures and subsequent behaviors indicated by the said gestures among individuals. Charmaz (1980) extends Blumer’s (1969) final premise that suggests people form and change meanings through an interpretive process. She adds that this interpretative process becomes apparent when people are confronted with any situational changes; while adjusting, they create new meanings that will become shared, internalized and part of their everyday life. In lieu of everyday life, Charmaz (1991) mentions habitual practices. She stresses that these created meanings will be part of individuals’ habitual practices in a way that does not necessitate any explicit interpretations of actions and interactions.

Since the behaviors of individuals take place based on their own particular meanings, there should be an appropriate method to study them. In terms of methodology, Blumer insisted that people’s comportments could only be studied through sympathetic introspection - getting inside of the world of the individuals of interest, seeing the world as they see it.
The Social Construction of Reality

Peter Berger and Thomas Luckmann (1966) argued that the social construction of reality means that people interact, participate in give-and-take roles through which they create, nurture, and share meanings which they respond to and which form the basis of their social practice to a level where these meanings become implanted in society as objective truths. The theorists were interested in unveiling the frames of meanings from which people organize their social worlds and suggested that the belief systems people form about everyday life are relative to their respective social experiences and respective needs. “What is 'real' to a Tibetan monk may not be 'real' to an American businessman. The 'knowledge' of the criminal differs from the 'knowledge' of the criminologist” (1966, pp. 2). This idea could be interpreted two ways. In one hand, it could mean the realm of knowledge is different for these different social agents. On the other hand, this idea could be interpreted as social agents having very different conceptual frameworks for the same topic. According to this theory, reality does not exist outside of the meanings people share. The existence of everything that is humanly consequential depends on the meanings people give to them. When it comes to knowledge, it is possible for communities to have different systems of facts and assumptions; they could also use distinct frameworks of meanings that lead them to organize and navigate the social world differently. What constitutes knowledge to the people of a community exists in a stock of knowledge – that framework within which meanings are created and human interaction occurs.
From this perspective, people are not tabula rasa; they are active agents who construct meanings that shape the reality in which they live. Actions, therefore, are based on those meanings rather than the empirical feature of the social existence (Blumer 1969, pp. 50). As Murphy (2012) explains, empirical descriptions are insufficient to provide any insight into the meaning of social life. In the case of this study, evaluating the infrastructure of a neighborhood, for instance, will not provide a definitive understanding of the real needs of the neighborhood during an epidemic. The world of these residents cannot solely be translated by empirical indices. Keeping in mind the example regarding the disaccord between the Haitian government and its partners about what should be prioritized, the meanings of ‘needs’ to the residents could be perceived differently. These needs are continuously reinforced through a series of actions and consequently learned through what ethnomethodologists designate as biography (Murphy 2012). To have access to this biography, it is important that the researcher has a channel of communication with the residents to reach to the constructed meanings. The perception of the public on what constitutes a health crisis is frequently not in sync with the focus of traditional research approaches. Kleinman, Eisenberg, and Good (1978) argued that it is therefore important to make an attempt to enter a studied community’s social world and understand things the perspective of that community.

Symbolic Interactionism and Constructivist Grounded Theory

The theoretical framework of symbolic interactionism fits well with the fundamental principles of grounded theory. According to Charmaz and Belgrave (2014), symbolic interactionism and grounded theory form ‘a useful theory-methods package’. Klunklin and Greenwood (2006) make the link between grounded symbolic interactionism and
grounded theory very explicit. The grounded theory methodological principles recommended by Glaser and Strauss (founding fathers of grounded theory) are paralleled to the methodological stance of symbolic interactionism advanced by Blumer (1969). They both put emphasis on the need for the research data to stem from a firsthand observation of the social world; for these observations to be questioned and analyzed; for categories to be generated; for theoretical patterns to be constructed and tested. Another methodological association drawn by the authors is the similarity that exists between what one could perceive as a rhythmic dance consisting of two steps: constant comparative analysis and theoretical sampling. Both grounded theory (GT) and SI encourage the researcher to partake in this dance to arrive at the development and validation codes and categories stemming from the participant observation (or interview) in GT or direct observation of the social world.

Grounded theory is a qualitative methodology through which researchers can construct a theory about issues meaningful to participants through a set of systematic strategies (Charmaz 2014). Researchers collect data inductively, and the theory emerges from participants’ narratives regarding the issue being studied. There are however other permutations of grounded theory which differ from the Straussian grounded theory adopted by Klunklin and Greenwoood (2006). Grounded theory method according to Glaser and Strauss emphasizes inductive reasoning, and the researchers’ vision within a clear frame, while Strauss put more emphasis on the systematic approach and validation criteria (Creswell 2013).

Based on the constructivist research paradigm that I used in this study, reality is socially constructed by individuals. Ontologically, the world is made of many individual
realities influenced by context. Epistemologically, reality is constructed by individuals in interaction. Given my ontological stance and my epistemological position as a researcher, the constructivist grounded theory described by Charmaz and Belgrave (2012) is the best fit for my study. According to Charmaz (2014), this version of grounded theory “assumes the relativism of multiple social realities, recognizes the mutual creation of knowledge by the viewer and viewed, and aims toward an interpretive understanding of subjects’ meanings” (p. 250). Constructivist GT puts emphasis on the subjective relationship between researchers and participants and assumes that both actors co-construct data and theory. The constructivist grounded theory differs from classic grounded theory in its core tenets. Researchers who use constructivist grounded theory take the perspectives of the participants into consideration and attempt to interpret how these participants construct their realities. The researchers are expected to immerse themselves in the data to enclose the story the participants in the research outcome.
Chapter 4: Methods

This chapter aims to explain the methodological approach to this master’s thesis. First, I describe the grounded theory research methodology, the study design, and the recruiting process. Lastly, I briefly present socio-structural features of Port-au-Prince, where I conducted my research. This study used a constructivist grounded theory methodology to address the following research questions:

1. To what extent has the cholera epidemic changed the daily lives of Haitians living in the country?
2. What kind of reality are they living in?
3. How are Haitians mending their reality following the various disruptions caused by the epidemic?

Constructivist Grounded Theory

In order to answer the research questions, it is necessary to enter the world of the population of interest. In terms of methodology then, the study followed the constructivist grounded theory approach described by Charmaz (2014) to generate a new theory about the reality of the participants’ everyday life. This contributed to the literature by qualitatively defining the reality constructed and shared by Haitians in their meaning framework. The use of qualitative methods to attain the study’s objective facilitated the adoption of a different ontology (Conrad 1987) and allowed for the exploration of Haitians participants’ experience of living in the midst of a cholera epidemic. It helped me understand the ongoing processes through which meanings are socially constructed,
interpreted, and bound to the participants’ practices (Charmaz 2014; Charmaz and Belgrave 2014). This social ontology followed the premises of symbolic interactionism (Charmaz 2014, p. 271). I had an opportunity to immerse myself into the world of the interviewees and remain as close to their experiences and their perspectives as possible by asking questions to identify interpreting categories and themes which were crucial to the analytical process. Such technique enabled me, in interaction with the participants, to construct a theory about their reality. With this method, “data do not provide a window on reality; rather, the ‘discovered’ reality arises from the interactive process and its temporal, cultural, and structural contexts” (Charmaz 2014, p. 524).

In terms of epistemology, when using the constructivist grounded theory approach, there are no unbending separations between the researcher and the research participants. The knowledge from each group of individuals is important in the process of analysis. As such, constructivist grounded theorists acknowledge their influence on the study while systematically analyzing the data through rigorous analytical practices and heeding the researcher-participant relationship. The knowledge of both groups of individuals is valued and part of the analysis. This way, knowledge is perceived as co-constructed by both participants and researchers in a particular context. Knowledge generates from a process of constructions and interpretation.

**Research Design**

The data for this study consist of thirty semi structured in-depth interviews with four follow-up interviews - all conducted exclusively in Creole to take the Haitian sociolinguistic dynamic into consideration. The follow-up interviews allowed me to clarify information collected from the first interview or cross-check information acquired
from other sources. In Haiti, languages have different values and functions (Valdman 2000). Although it is not uncommon for Haitians to be bilingual (speak French and Creole), Haitian Creole is more widely used in everyday communication, and is considered the symbol of the national identity (Valdman 2000). This approach helped me maintain some linguistic consistencies throughout the research process. Prior to conducting interviews, I visited different areas of Port-au-Prince. I took a few pictures of the built environment and took field notes on what I observed to add to my understanding of the field of study prior to meeting any interviewees. All interviews were recorded and transcribed verbatim to preserve the words of the participants. Next, I proceeded with the analysis of data in order to develop concepts and working hypotheses to examine in subsequent interviews. The collection of data lasted three months.

I first travelled to Haiti following my encounter with a participant who suggested that I conduct a study on the cholera epidemic in Haiti. During my visit, I aimed to see the epidemic in action, re-familiarize myself with the capital and the culture, and recalibrate my Creole speaking skills to the current time. In the course of two weeks, I visited different parts of Port-au-Prince and shadowed three individuals: a family member, a maid, a student. I travelled a second time prior to my proposal’s defense to prepare the field and pilot my interview guide (Appendix B, p. 117) following my IRB approval. I conducted three interviews and coded them for preliminary results. I refined the Creole version of my IRB approved questionnaire and recruitment script to be culturally appropriate and semantically valid. Lastly, based on the feedback of local residents, I made a few changes to my protocol regarding certain proceedings which were approved
by the IRB within two days. Following my thesis proposal’s defense early May, I went back to Haiti right away where I continued collecting data until July.

The number of interviews was not arbitrary as the research approach in question is not dependent on a sample size. It is rather dependent on how far I dig into the collected data by the means of the theoretical sampling technique until I discover no new information (called theoretical saturation). Theoretical sampling is a way to reveal variations in the collected data and identify gaps that require elaboration (Charmaz 2014). Charmaz (2014) explains that the interviewing process is a negotiated development that occurs in the participant’s context; it is within this context that the experience being studied resides. In-depth interviews are great tools that facilitate the digging required for a focused search of specific themes into the interviews and to maintaining a close proximity to the interviewees’ perspective required for a theory to be developed. Furthermore, in-depth interviews allow an outsider to have an extensive look at experiences lived by a group of people (Johnson and Rowlands 2012). In addition to that, a semi-structured interview could also expose the tensions and contradictions of individuals regarding their experiences (Savoie-Zajc 2004).

The researchers’ influence is a potential pitfall if they are members of the community being studied (Johnson and Rowlands 2012). Being aware of the potential influences of ones’ experience on the participants’ stories throughout the interview process should lessen the magnitude of this challenge. I was born in Haiti and emigrated as a teenager. My connection to the community was not anticipated to be a major hindrance since in-depth interviewing, according to the authors, is an interactive process in which both parties are able to bring about a level of clarity in their exchange by communicating.
Furthermore, the theoretical underpinning of this study recognizes that individuals’ experiences and definitions vary. I was cognizant of this aspect.

**Recruitment**

The majority of participants were selected through a snowball sampling process. The starting points of the participant recruitment were my personal contacts, which consisted of acquaintances from various background (medical and non-medical professionals, graduate students, housewives, maids etc.), friends and a family member. These initial participants were contacted before my arrival to the field of study via email and phone and were given a description of the study. If they agree to be interviewed, I gave them a thorough overview of what to anticipate once I arrive to Haiti (interview scheduling, consent forms, questions), shared the criteria of the study’s participants and asked them for referrals to other people who preferably live in their neighborhood. As previously discussed, the perpetuation of the cholera epidemic is heavily dependent on the state of a region’s infrastructure and other geographical factors which partially explain the uneven distribution of cholera cases across the country. For Port-au-Prince, studies have shown how neighborhoods are disproportionately impacted by the health crisis and how geography plays an important role in this (Page et al. 2015). Following my visits to different parts of Port-au-Prince, I noticed that people from different socio-economic status can reside in the same neighborhood. Individuals who are considered part of the middle class or *gran neg* ⁴ by their neighbors had a different way of life, and had more possessions (i.e. car, water tank, inverters, etc.). In a neighborhood I visited in

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⁴ A person who is considered to be well off in relation to the have nots.
Delmas 32 for instance, some houses were imposing and had elaborate structures. On that same block, other houses were either less elaborate (maybe not painted or have not backyards), or looked ramshackle (made out of a steel-like materials, like pieces of a container). There were houses made of concrete that had visible fissures sustained during the Earthquake of 2013. I began paying attention to the participants’ lieu of residence and their occupation. Because of the variations in social and economic structures of the field of study and the theoretical underpinning of the study, I did not aim to focus on one type of individuals and analyze a group independently from other groups or individuals. To the best of my abilities, and especially in accordance to who was available to meet me, I recruited individuals in relations to each other. For example, since I had a restaurant owner, I sought the account of a street vendor; I recruited professors and students; employed, underemployed and unemployed. Additionally, I made sure that all potential participants met the study’s criteria and then answered any questions they had about the research study. Selected participants met the following criteria: (1) Haitian born; (2) resided in Port-au-Prince before the emergence and spread of the infectious disease in 2010 (3) currently reside in Port-au-Prince, Haiti. Given the issue of stigma surrounding cholera, I bypassed getting the disease as a criterion.

I scheduled interviews at the Observatoire de Recherches sur les Rapports Élites-Populations et les Migrations [Research Observatory] located in downtown Port-au-Prince. Seven interviews were conducted at the place of work of the participants. I also recruited and interviewed a few people during my explorative outings. I successfully interviewed thirty individuals; I got rejected more than nine times during the recruitment process and had two no shows. I discarded three interviews due to eligibility issues
discovered post interviews. The majority of the interviews were conducted before 5:00 pm. Only two interviews were conducted after 6:00 pm for the convenience of the participants. During my outings, I was always accompanied by someone, either a friend or a family member – all residents of Port-au-Prince. I was never accompanied by someone while conducting an interview. Lastly, I obtained the formal consent of all participants verbally with my recording device prior to each interview.

**Data Collection**

I always brought the Creole version of my IRB approved interview guide (Appendix D, p. 122), comprised of open ended questions, to each interview to stay on track with the study’s objective (see Appendix B p. 117 for English Version). As Belgrave and Charmaz (2014) discussed, this choice is a matter of personal preferences. Nonetheless, as Charmaz (2014) suggests, I remained open to the direction that the participants took. To further help me in my analysis, I took field notes along with the interviews (Russell 1999).

I recorded all interviews and I made it clear to the participants that the interview was confidential as stipulated in the IRB protocol. I asked the participants to pick a pseudonym of their choice. Later on, I changed some of the pseudonyms as some of them were nicknames which could be potential identifiers. All interviews were diligently transcribed within forty-eight hours. The interviews were transcribed verbatim. I checked the transcripts for accuracy, coded them and analyzed at last. Interviews lasted between forty-five minutes to two hours; the transcripts were at least ten pages long. All these documents were stored in my password-protected personal computer. I destroyed the audio file of the interviews following their transcription.
After the transcription of the first interview, I proceeded with initial coding of the interview data line by line. At that point, I collected and coded interviews simultaneously (one interview at the time) after coding them line by line, and writing ideas about the data (memoing). I kept field notes after the interviews as well (one double sided page per interview) to retain additional information that cannot be captured on the tape (i.e. my thoughts on a participant’s reaction). I assembled these line by line data to form rough categories of similar characteristics. This was useful later on to manage categories through the coding process and generate conceptual categories (Charmaz and Belgrave 2015). I proceeded by comparing the early data to generate categories until new data were no longer significantly different and gaps had been filled. I began sampling to fulfill categories and recalibrated the interview questions accordingly (Charmaz and Belgrave 2014). Throughout the process of analyzing the data, I kept memoing, comparing and contrasting data across all interviews as concepts emerged.

Data Analysis

After the first three interviews, the initial process allowed me to modify the interview guide in terms of rephrasing and attuning the interview guide to the appropriate vernacular and cultural context. This initial coding consisted of sorting the data and systematically naming, labeling and interpreting patterns in the interview data line by line. I attempted to remain as close as possible to the language used by the participants when developing these codes. I built on these codes as transcripts were ready for coding. I conducted focused codes which consists of linking initial codes to label, organize, synthesize and categorize them to make patterns more explicit in order to conceptualize the participants’ experience (Charmaz 2014). The patterns stem from the interpretation of
the initial codes. As I compared codes between transcripts, I was able to modify or expand constructed codes.

From the focused codes, I identified patterns in the data by linking conceptual categories. I wrote memos to keep track of the rationale behind the connection between codes, how they formed categories and the meaning of these categories. As Charmaz and Belgrave (2012) explained, memos allow the researchers to be cognizant of their initial interpretations of the data and remain in close proximity to the research participants’ words. This tool, which consists of analytical statements and the experience of the researchers, is especially instrumental when researchers compare codes to previous empirical work and theories. This process of linking the codes to the existing literature makes the onset of the construction of major theoretical themes. Memos could also be used to identify gaps in the data and the analysis. Memos are also helpful to decide what questions to ask in subsequent interviews to expand on burgeoning categories, further constructing them until they are saturated. After thirty interviews, I felt like I had reached a level of saturation. Since additional research questions were developed after initial coding interviews, I conducted four follow-up interviews to further theoretical sampling.

In order to construct a theory that captures significant meanings within the context of living in mist of a cholera epidemic in Port-au-Prince, Haiti, I transitioned from findings to theoretical categories using inductive and adductive logic (Charmaz 2014). To construct theoretical categories, I compared codes and memos (described in previous stages) to the broader theoretical and empirical literature. This allowed me to sieve similarities and differences. Charmaz and Belgrave (2012) recommend mapping memos and links between categories. I visually integrated codes, categories and nascent themes
to have a bird’s eye view of the analytical findings from the data. Contrary to my plan, I did not use NVIVO, a qualitative data analysis software, to sort codes, categories, and organizing them according to memos. Given the frequency of electrical black-outs, I opted to manually sort codes, categories, and organized the data on the walls of an empty room with a plethora of colored post-its, papers and markers. I primarily relied on non-electrical tools (natural sun light, solar powered lamps, candles) in lieu of electricity. Although this manual process was grueling and time-consuming, it facilitated a level of continuity with less interruptions throughout the constant comparative method. If I were primarily relying on electric powered tools, I would have been less able to adhere to the crucial aspect of a grounded analytical approach: constant comparative method. The interview process was not affected as my recording devices were battery powered. I hired two professional transcribers who transcribed less sensitive interviews. For the rest, I transcribed myself on my personal laptop. I would then print the transcripts after I formatted them according to my preference\textsuperscript{5} for initial coding. Eliminating the use of a software in this process is not peculiar as the intuitive nature of qualitative research relies on the researcher whose abilities are not assisted by the device (Stroh 2000).

From there, I drew diagrams with post-it by hand that consisted of what would have been nodes on NVIVO. To mirror the recommended steps by Charmaz (2014), I compared the diagrams to the initial code described at the beginning of the analysis. The iterative process of data comparison between the different stages of this analysis is a sine

\textsuperscript{5} Double space with large right margin for initial codes.
qua non to the generation of a theory that is close to the experience of the research participants.

To address certain structural hindrances to my progress – electrical black-outs being the most debilitating - I acquired vital instruments: solar powered lamps, three rechargeable laptop batteries, and a backup phone charger. Nonetheless, the speed of my progress was still attenuated primarily by some prolonged electricity outages.

**Socio-structural Features of Field Work**

Currently the poorest country in the Western hemisphere, Haiti is a free market economy with low labor costs and tariff-free access to the US for its exports (CIA 2015). Port-au-Prince, Haiti’s capital, is the country’s largest metropolitan area as well as its commercial center. It is located in the West Department, which would be the equivalent of a state in the American context. It is located 62 miles south of the department where the cholera outbreak started. The capital is divided into six communes, or districts. I visited parts of Delmas, Champ de Mars, Petion Ville, Carrefour which are distinct in terms of their demographic compositions and characteristics, ranging from affluent suburban to extremely poor urban neighborhood. I also explored parts of Canape Vert, Turgeau, Bourdon, and Downtown. Much of the city sustained major damages during the Earthquake of 2010, which exacerbated an already distressed infrastructure (Schuller and Levey 2014; Lantagne et al. 2013). The myriad of buildings built under no construction regulations and the uncontrolled urban overcrowding have magnified the effects of the natural disaster (Shultz, Marcelin, Madanes et al. 2011). The city is surrounded by a variety of shantytowns which are on the hill side of the capital and the majority of its residents live on low incomes (Britannica 2015). In terms of settlement patterns, the
population in the countryside continues to grow and migrate to major cities. Roughly twelve percent of the Haitian population do not live in the department in which they were born and 80% of this group settle in the West Department (IHSI 2001). In 2010, it was reported that approximately three million people were living in the capital while the population of Haiti was reaching 10 million people (UNICEF 2012).

Slightly more than half of the Haitian population is estimated to be less than 25 years old (CIA 2015). The majority of Haiti’s population is of African descent while a small minority of people who are of mixed European and African descent constitute a wealthy elite (Britannica 2015). The country has two official languages; Creole is the language used in everyday life and French is the institutional language. In 2010, 7.9 percent of the country’s GDP was dedicated to health expenditures; the life expectancy is 63 years old (CIA 2015).

Participants’ Profile

There is a total of thirty participants: thirteen females and seventeen males. Of the fifty participants, only half of them revealed their exact place of birth. The rest of the participants simply indicated the department in which they were born. These locations were categorized by cardinal directions to indicate which part of the country participants are from. Three people were born and raised in Port-au-Prince; one person was born in the West department, outside of Port-au-Prince. Six participants were born in the North and five in the South. From my understanding, it is quite common for some people to indicate the department of birth than the place or exact city of birth. From the information

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6 Haitian Institute of Statistics and Informatics
I gathered, people’s place of birth could expose them to discrimination when living in a major city in which they were not born – especially if they are from distant urban areas.

In terms of age, only twenty percent of the participants either provided an exact age or indicated an age group. The youngest participant is eighteen years old, and the majority of the participants are over twenty-one years old. Of the thirty participants, eight of the participants are unemployed and actively looking for a job; six of them are students. The majority of the students are attending college on a full time basis. In that group, there is only one high schooler and one-part time college student who also works as a full time social worker.

Table 1 – Participant’s Current Occupation

<table>
<thead>
<tr>
<th>Administration</th>
<th>Driver</th>
<th>Maid/Maintenance Staff</th>
<th>Professor</th>
<th>Restaurant Owner</th>
<th>Soc. Worker/Case Manager</th>
<th>Student</th>
<th>Street Vendor</th>
<th>Other Employed</th>
<th>Unemployed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
</tbody>
</table>

At the beginning of the data collection process, I asked background at the end of each interview if the participants did not disclose any pertinent information beforehand. (see Appendix B, p. 117). A large number of participants were not comfortable answering certain background questions (age, education attainment, marital status etc.). I identified
this discomfort after the tenth interview. Thus, I opted to gather background information by cautiously probing for these types of information throughout the course of the rest of the interviews. When a participant seemed uncomfortable or reluctant to answer these questions, I changed the topic right away. I provided a mini introduction for each participant to help the reader know a little more about the participants (Appendix A, p. 110).
Chapter 5: Findings

This chapter constitutes the heart of this study as it presents the findings of the study conducted in Port-au-Prince, Haïti. Data were collected to address the following research questions: To what extent has the cholera epidemic changed the daily lives of Haïtians living in the country? What kind of reality are they living in? How are Haïtians mending their reality following the various disruptions caused by the epidemic?

From the interviews conducted in Port-au-Prince, it was found that all participants experienced some form of trauma during the 2010 earthquake. Many of them felt that the emotional and physical wounds that resulted from the earthquake were still fresh when the cholera outbreak occurred. Filip clarified, “each phenomenon came with a series of tragedy that cannot be separated from each other.” Although the amount of details provided on the matter varied across participants, they unanimously agreed that the earthquake and the epidemic come as a disaster package – natives discuss them in relation to each other. Some of the participants described the fright they experienced while the earthquake happened. I created the initial code “experiencing fear during EQ” to capture the feelings. Manouchka, who was selling fresh produce at a local farmer’s market at the time, explained the way she felt when the natural disaster struck:

I was at the marché\(^7\) that day. Business was slow, so I started threading the needle to mend some clothes. At first, I thought that the ground moved because of an accident – wouldn’t be the first time. But the shaking didn’t stop; buildings started coming down. My intestines boiled.

Other participants had similar experiences of fear. Moonie was on a school bus ride back home when she saw the Haitian Cathedral of Our Lady of the Assumption collapse.

\(^7\) Outdoor market.
Many participants recalled experiencing intense emotions. Varice, who lost his wife, stuttered:

“I didn’t know what to...my kid, my wife. I was cold, but I kept sweeting you know. My legs gave in several times, but I had to...my mouth was dry. I have never been so...I can’t.”

Other participants briefly recounted what they were doing when the earthquake occurred with gloom and sprinkles of humor. Some described their initial reactions to either losing a close one, seeing dead bodies or crushed limbs for the first time in their lives. I initially coded these as “feeling emotions post-earthquake.” Manou, a social worker, recalled that he could not stop eating sweets, which he identified as a coping mechanism. He said: “Ok no one died in my family. But there was so much bad news that I couldn’t stop eating sweets to deal with the sadness. I even ate sugar when I didn’t have candy.”

Other participants alluded to developing unusual behaviors and provided a rational for them. They reported avoiding concrete buildings, needing to sit near the nearest exit when indoors or frantically examining the structure of most edifices before entering them. The initial codes formed the category “seeking reassurance/safety.” On Table 1 below are more examples of initial codes from cholera portions of the interview:
<table>
<thead>
<tr>
<th>Initial Codes</th>
<th>Words of Participants by Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>Going everywhere w/ hand sanitizer</td>
<td>“I don’t go anywhere without my hand sanitizer” (Filip)</td>
</tr>
<tr>
<td>Being more inclined to wave hands than hug</td>
<td>“I prefer waving hands to hugging since the outbreak” (Lou)</td>
</tr>
<tr>
<td>Being more inclined to kore (fist bump) with occasional hugs</td>
<td>“I used to kore everyone when things were worst, I still do it now but I hug occasionally” (Gary)</td>
</tr>
<tr>
<td>Limiting physical contact with non-family members.</td>
<td>“I touch my family members...others with limits” (Romain)</td>
</tr>
<tr>
<td>Using Clorox often</td>
<td>“I could I would wear no dark color clothes to avoid bleach stains” (Moonie)</td>
</tr>
<tr>
<td>Drinking bottled water</td>
<td>“If it is not bottled, I don’t drink it” (Jean)</td>
</tr>
<tr>
<td>Avoiding kiss of peace at church</td>
<td>“I avoid the baiser de paix at church, I can’t help myself” (Kately)</td>
</tr>
<tr>
<td>Avoiding fritay (a type of fried food)</td>
<td>“I loooove fritay but only look at it now” (Kately)</td>
</tr>
<tr>
<td>Avoiding crudité</td>
<td>“I stay away from crudité...if it’s not cooked I’m not interested” (Ben)</td>
</tr>
<tr>
<td>Observing/Critiquing mother’s compulsive cleaning habits</td>
<td>“It’s almost impossible to live with my mom, she’s always cleaning to this day. It’s crazy.” (Moonie)</td>
</tr>
<tr>
<td>Brushing teeth with Culligan /preferring Culligan water</td>
<td>“I brush my teeth with Culligan water only now and I’d shower with it too if it wouldn’t ruin me” (Varice)</td>
</tr>
<tr>
<td>Using Clorox in everything</td>
<td>“My boss wanted me to use Clorox in everything: dishes, water, cleaning” (Manouchka)</td>
</tr>
<tr>
<td>Observing regression to old habits</td>
<td>“I think people went back to their old habits” (Marj)</td>
</tr>
</tbody>
</table>
The initial codes are directly related to the data – the participants’ stories. During the initial stage of the analysis process, I went through the data several times and then created labels for lines of data that summarized what I saw happening (see Table 5.1 above). These various codes have a temporary attribute, and in the course of the analytical process, as I searched for similarities and differences by constantly comparing them, they grew into more distinct and abstract concepts. These distinctive concepts are categories. I further defined and fleshed out these categories by drawing connection with data with more focused codes. Proceeding as such, I demarcated six categories: dealing with earthquake’s aftermaths, being hit by cholera aftermaths, living in fear, making adjustments to protect health and self, facing challenges, adapting to the cholera epidemic. The categories (see Table 3 below) are organized in a sequential order to follow the progression of the epidemic over time. This order starts with the time that precedes the epidemic, progresses to October 2010 when the first cholera cases and deaths were reported in October 2010. Shortly after the initial reports, the cholera outbreak became a widespread nationwide epidemic – the peak of the epidemic. As time passes, the number of cholera cases and deaths progressive decrease. This format was adopted because the lay understanding of the epidemic’s timeline is in agreement with the timeline of several epidemical reports. Pre-Cholera Epidemic is the period preceding the cholera outbreak when people were still recovering from the earthquake’s aftermaths. Peak of Cholera Epidemic – October 2010 to 2012 coincides with the short transitional period from a regional outbreak to a nationwide epidemic during which Haïti saw the highest recorded cholera case fatality rate. Time elapsed as the skyrocketing cholera related deaths slowly decreased in a vacillating motion. Last is Post-Cholera Epidemic
coinciding with the present (2016), when this research’s data are collected. Compared to previous years, the level of fear, panic, and death related to cholera during this latter temporal category is relatively bearable.

Table 3 – Categories and Descriptions

<table>
<thead>
<tr>
<th>Categories</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-Cholera Epidemic/Post Earthquake</strong></td>
<td></td>
</tr>
<tr>
<td>Dealing with earthquake’s aftermaths</td>
<td>The cholera outbreak occurred in 2010, roughly ten months after the earthquake. All participants described the weeks after the earthquake as a period of “darkness,” “pain,” “terror,” “confusion.” As the months passed by, it became a period of “mourning,” “transition,” “reconstruction,” “hope,” “togetherness.” Two of the participants accompanied family members who emigrated following the destruction of their houses. Another participant lost a family member. When the rate of cholera related deaths skyrocketed soon after the announcement of the outbreak, all participants reported being incredulous. The occurrence of the outbreak was compared to an overkill. Additionally, the Haitian population was trying to make sense of this unfamiliar disease which lead to the use of various explanations about how cholera came to arrive in Haiti.</td>
</tr>
</tbody>
</table>

| **Peak of Cholera Epidemic – October 2010 to 2012** |                                                                                                                                                                                                              |
| Being hit by cholera’s aftermath               | All participants unanimously pointing to the short time between the natural disaster and the infectious disease outbreak. “There was not enough time to breath.” Only one participant reported being in convalescence after having cholera. Two other participants described their experiences with false alarm. The rest of the participants provided details on their surroundings. Around them, people thought that 2010 was a cursed year. They were particularly affected by the death tolls, and reports |
on the conjuncture and the widespread fear from dying of cholera.

| Living in fear | The period with the most cholera related deaths was perceived as period of fear and chaos. All participants dreaded catching the disease at various degrees and for different reasons. Concern and fear varied especially according to occupational status, and finances. The participant who previously had cholera dreaded a recurrence— refusing to re-live the imminent isolation, humiliation, and taunts that come with the sickness. Participants reported feeling “stressed,” “worried,” “concerned” over the matter. Others considered this period as pandemonium. They provided detailed accounts on their experience and that of their surroundings during this period of fear. |
| Making adjustments to protect health and self | Making the necessary adjustments to lower one’s risks of having cholera entailed adhering to health safety measures; Stocking disinfectants in bulk; Taking extra health precautions; Changing daily practices; Changing behavior; Visiting doctors more often; Revising hygienic practicing; Informing others on potential risks of getting cholera; Being a hygiene martinet; Distancing self from others; Allocating more money to purchasing quality water; Budgeting for sanitation; Paying more attention to the state of environment; raising hygiene and sanitation standards; Maintaining strict health safety (over the years) |
| Facing challenges to maintain safety measures | With the epidemic, people enforced or re-enforced certain measures to protect their health. Over the years, some participants faced certain challenges that increasingly deter them from adhering to their protective measures.  

**Behavioral:** Many participants reported avoiding close contact with non-family members. Such restriction was difficult to maintain as other people from their various social circles progressively... |
discarded this behavioral change over time. Some participants expressed their unwillingness to be perceived the wrong way or ridiculed by others. They reverted back to old practices before the cholera epidemic: hugging, hand shaking, close contact.

**Infrastructural and Environmental:** poor water and sanitation infrastructure. Not all places are conducive to the maintenance or adherence to guidelines for cholera prevention. Participants explained the impact of their neighborhoods on the likelihood of having consistent hygienic practices. Many of them deplored the lack of water availability in public spaces, the mismanagement of detritus as well as the way others treat the environment. Example: deposal of defecations that are later exposed on the streets by overflown waters due to no citywide canalization system.

**Emotional and physical:** Participants shared the emotional and physical tolls of the epidemic that negatively influenced the adherence to guidelines to prevent cholera over time. Participants mentioned being discouraged from using bleach as often as they used to because of the number of clothes ruined, rashes on skin, stomachaches. These problems prompted the majority of them (but one), to ease their disinfection regimen.

**Economic:** Some participants, especially those who are unemployed or underemployed began to struggle carrying the economic burden of the cholera epidemic. The participants broke down the complex decisions they have to make in their everyday lives choosing between food and purchasing quality water. Participants working in the service sector reported that the epidemic made it harder to retain jobs while “looking like someone who can have cholera.”
Adapting to the cholera epidemic

Reassessing habits adopted during the peak of the epidemic to protect one’s health. Six years later, all of the participants reported that living in the midst of the epidemic is not the same as before. Many of them reported a level of adaptation to the situation. Some of them are no longer concerned with catching the disease. They protect their health and remain informed on the evolution of the epidemic. Such outlook varied among participants as many of them admitted that adapting to the epidemic and following the guidelines to prevent cholera are contingent on “sa’w gen nan men’w.” It is a common understanding that those without the means are more at risk of catching the disease as they are not able to meet the health safety standards to prevent cholera. i.e : buying purified water, having a modern bathroom, trash container, etc.

### Pre-Cholera Epidemic/ Post-Earthquake

The period preceding the onset of the cholera outbreak in the Artibonite region was often designated as a period of reconstruction. According to the participants, there was a lot of agitation during that time. Many people emigrated looking for refuge or medical care in other countries. Others moved to displacement camps following the destruction of their houses. Individuals who had nowhere else to go occupied vacant properties; others looted. Tent cities spread throughout the capital. At that time, Sofia was concerned for her family’s safety specifically that of her daughter as rapes and sexual assaults were escalating in displacement camps (Davis 2010). Damages were being assessed all over the capital in order to start the rebuilding process. All participants described the ten months leading to the outbreak as a period of “darkness,” “pain,” “confusion.” As the

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8 Sa’w gen nan men’w = amount of money you have in hands; purchasing power.
months passed, the collapse lead many to speak of the time as a period of “mourning,” “transition,” “reconstruction,” and “togetherness.” Gary and Lou accompanied family members who emigrated from Haïti following the destruction of their houses; Varice was mourning the loss of his wife. With the upsurge of cholera related deaths following the announcement of the outbreak, all participants reported being incredulous. Participants often compared the occurrence of the outbreak to the decimation of the Haïtian population. People’s attempts to make sense of this unfamiliar disease led to the use of various explanations about the origin and the etiology of, what was then, a mystery. Dax explained the way he and people around him felt when the cholera outbreak started. He shared:

We were still trying to make sense of that goudou goudou⁹ when rumors started on something, just a thing, killing people in Artibonite. We didn’t know what to make of it. And you know how Haitians get…there were some crazy stories out there. My sister was so scared. She spent hours in church praying for protection. I was a little afraid too, but I was more confused.

Of the thirty participants, only one was not in the country during the onset of the cholera outbreak. Gary explained:

Many of my family members emigrated after the earthquake. I left the country to be with them for a few months. That’s when I heard of some disease spreading in the country on the radio. Let me tell you, when you’re out of the country, don’t listen to Haitian radio. The news will petrify you, you will not live.

Peak of Cholera Epidemic – October 2010 to 2012

Being Hit by Cholera

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⁹ Earthquake in Creole.
People were still in an earthquake daze dealing with losses, chaos, and pain when the cholera outbreak occurred, causing widespread confusion. My findings echo the findings of Grimaud and Legagneur (2011) and further corroborate the fact that cholera was understood differently across communities. Only one participant, Drogo, a medical student, reported hearing of the infectious disease prior to the outbreak in 2010 while the rest of the participants had never heard of cholera before. When the Haïtian government declared a public health emergency, the announcement confirmed rumors about a mysterious disease wreaking havoc in rural areas. All participants seemed especially marked by the confusion surrounding the etiology of that disease as explanations and perceptions of the epidemic varied greatly. I gathered four explanations about the etiology of the disease. Two explanations stem from a biblical context, the second one from a mystical context, and the last one stems from a scientific context.

The earthquake was not part of our reality. Prior to 2010, you didn’t hear people on the streets talk about earthquakes. It took us time to truly grasp what an earthquake was, scientifically speaking. Then right after that came an outbreak. We are no strangers to outbreaks but we were not familiar to cholera. What was that! So naturally, in a society like ours - and we saw that back in the days with AIDS - people tried making sense of the foreign disease. (Filip)

The first biblically rooted explanation includes two versions that pertain more to the macro level framework. The first one was that cholera was the will of God who has a bigger plan for people. Per the second version, God was punishing Haïtians for their sins. The deaths of many Haïtians from the earthquake and cholera were seen as a mean of purification to wash away those sins, almost like a cleansing process. Ponyo, an accountant, explained:
I believe that. There is so much corruption, so much move deal,\(^{10}\) so many people who are suffering because of what our leaders have done…we are all paying for the sins of our leaders, our fathers, and brothers.

That same explanation is relayed at a more micro level where people perceived the disease as an ailment suffered from those not adhering to the Christian faith – that makes the concerned individuals sinners. Rick, who considered himself an agnostic, provided the details:

My dad is a fervent protestant. For him, we are all dealing with the consequences of sinners’ actions. He would go on: ‘they don’t want to accept God in their lives, they rather serve the devil. We are paying for that!’ And this ‘they’ to which he is referring is vodou followers.

From a follow-up interview, Rick clarified that there are two types of consequences to which his father alluded to. The first type of consequence is connected to cholera suffers; they caught the disease because they are paying for their own sins. The second type of consequence is connected to different pivotal ceremonial events in Haïtian history that involved vodou practices that in the Bois-Caiman ceremony of 14th August 1791 during which slaves made a pact with the devil to rid Haïti of colonizers. To Rick’s father, the current state of the country and the series of disastrous events in Haïti are consequences of this vodou pact.

Connected to the individual sinner explanation is the understanding that cholera is a caste spell, \textit{yon malady moun ka voye so ou}.\(^ {11}\) In this sense, a person can throw \textit{poud kolera}\(^ {12}\) on other people and make them sick. Interestingly, while Grimaud and Leganeur do not report any stories of individuals throwing the “cholera powder” at each other, they

\(^{10}\) Murky back door deals.

\(^{11}\) A spell cast upon someone that makes them ill. It is a supernatural disease.

\(^{12}\) Cholera powder containing the spell that can give one cholera.
found that members of some rural communities believed that vodou practitioners caused the epidemic by dumping a “cholera powder” into water sources. Lala, member of a Christian prayer group, acknowledged and used the scientific explanation of cholera. She specified that although science can explain the disease, the illness is not natural; it is not God’s disease – meaning that it can be human made. Lala explained: “the way they [the sick] suffer is not always simple.”¹³ That is why we pray for them, it is our Christian duty. We are Jesus’ soldiers.” People who ascribed to this perception saw the disease as a phenomenon linked to the earthquake, and both are part of a series of events connected to the predictions of the book of Revelation – the Apocalypse. Filip explained:

That’s how a lot of people who identify as Christians, especially Protestants, explain it. To them, this is just the beginning. More disasters are to follow. Nowadays, the disease is discussed in church from a scientific perspective; however, many people still hold on to these other hypotheses.

All participants reported being exposed to these diverse explanations and only a few openly expressed their opinion on the matter. Marj understood and acknowledged cholera as an infectious disease and described the life cycle of the disease. She also entertained the idea that the disease could be a bioterrorist attack:

I wouldn’t be surprised if the disease was introduced in a way for blan an⁴ to infiltrate the country and get rid of us… I’m not the only one who thinks that. I’m just more outspoken than others. I wouldn’t be surprised at all if there was a genocide attempt. I’m not saying it is. I don’t have any proof, but in the back of my mind I can’t help but think that with the way things are in this country with those blan and our puppet government.

¹³ Simple here means that it is something malevolent that is intentionally done to someone
¹⁴ Literally translated: white people. Refers to imperialist countries involved in Haiti – U.S.A, France, Canada etc.
Filip believed that this plurality in the understanding of the disease stems from the existence of different meaning frameworks among individuals in the population. Later on, Ben added that the high level of illiteracy could explain why the scientific framework, which is supposed to be the dominant framework, does not prevail among the masses and coexists (sometimes competes) with the biblical framework when it comes to cholera. Based on his explanation, a lack of education impedes the individual’s socialization into the scientific framework. Rick gave a similar explanation. Pete, a case manager, echoed these ideas but added more:

But it’s not only about a lack of education. People assume that if you think that God caused this disease, they must be illiterate or not enlightened. That’s not true! There are people with no formal education who are more articulated, logical and scientifically driven than those who went to school. Listen, people are suffering so much out there, they are way over their head, they need more. They need something that science can’t always offer. I worked with a woman, who lost two kids during the earthquake, they never found the bodies. One year later, her husband, a medical doctor, died from cholera. In my experience, science doesn’t always provide enough closure. ‘Why me?’ they’d ask. Religion is the only thing that seemed to give my clients a dust of solace and come close to give an answer to that question. I worked with many well-educated people; others are not. I personally don’t see a big difference in the way both groups navigate between the two ways of seeing thing. At the edge of absolute despair, Haitians turn to God or the divine. The Earthquake showed us that clearly.

Lily and Zola, the youngest participants who are both attending Christian schools, simply mentioned that not all of these explanations made sense as they ascribe and are more familiar with explanations deriving from the scientific framework: cholera is an infectious disease. Santia, whose sister survived the disease, explained:
There were days *mwen pa we anwo, mwen pa we anba*\(^5\). Have you ever seen someone with cholera? Not pictures. You want to retch when they vomit; you dread the white diarrhea that feels a bit warm on the plastic bag that protects you against them while holding them in your arm. In a few days, a person who was always *plen kon ze peyi*\(^6\) becomes the size of a broom. THIS can’t be a simple malady. The doctors can treat it, but God has the final word.

Participants painted the beginning of the cholera epidemic as a time of confusion and ideological cacophony. Explanations and ideas about the pathology of cholera varied greatly among residents of Port-au-Prince. These diverse explanations stemmed from the biblical context, the mystical context and the scientific context. At that time, as the population was newly confronted with this new disease, the dominant explanations used to make sense of it stemmed from a biblical and a mystical context. People believed that the epidemic was a punishment for sins committed by individuals in the populations. Others thought that vodou practitioners caused the disease with a mysterious powder they concocted. With the publication of reports exposing the involvement of the UN in the introduction of the disease in the country, other individuals perceived the epidemic as a bioterrorist attack orchestrated by certain imperialist nations, notably the United States, to justify their present in Haïtian soil. As the months went by, these distinct ideas began to crescendo.

**Living in Fear**

The cholera epidemic’s conjuncture of high mortality, confusion, and ideological cacophony was propitious to the emergence of fear. All participants dreaded catching the

\(^5\) I am upside down. Literal translation: I don’t see up; I don’t see down.

\(^6\) Full like a local egg. Usually to denote plumpness and healthiness.
disease on different levels and for different reasons. During this time of frenzy, Romain had cholera:

I shared a plate of fried fish and plantain on the street with my friend. He brought too much and offered me some. Later, I didn’t’ feel well, and thought that it was a simple indigestion. I was walking to my sister’s when I started vomiting and I shitted on myself. I couldn’t stop. When I opened my eyes, I was on a table with my ass sticking out of a hole. I kept vomiting a clear liquid. I was scared, mad…ashamed.

Romain is the only participant who had cholera and was treated at the hospital. During his convalescence, Romain lived in fear. Although a nurse educated him on the pathology and the biology of the disease, he dreaded spreading it to his family who received death threats from their neighbors for housing him. He recalled:

My neighbors threatened to burn me alive and chop me up with a machete if I got out of the house. They thought that they would get sick from the air I breathe. I stayed inside and only went out at night when people slept…this went on for months – like a year, yeah. The police did nothing. I was blamed for giving *latchouloulou*.\(^\text{17}\) (Romain, 33.19)

In the neighborhood, friends and extended family members excluded his family from social activities. They no longer visited or sent their kids to play with the nieces and nephews of Romain. His sister’s best friend stopped coming for prayers and exchange goods. The best friend with whom he shared the contained food spread the news about his health to all of their mutual contacts. Since the health of his former friend was intact, his family members believed that this latter tainted the food with the cholera powder. Aside from his immediate family members, no one talked to Romain, let alone touched him, for a while. Nowadays, while people are relatively more accepting of him, he is mercilessly taunted on the streets for his past health condition. They call him names like

\(^{17}\) Other name for diarrhea.
kakatoue\textsuperscript{18} or cholera.\textsuperscript{19} When he asked people to stop taunting him, they tend to retort that he lacks a sense of humor. “I don’t think they’d be laughing if they were in my place,” muttered Romain. Rick, a college student, admitted that he got so scared that he thought he had cholera after getting food poisoning from leftovers. He admitted himself to a cholera treatment center and found out that he only had food poisoning. Varice, a professional, started feeling weak and dizzy after watching a documentary on cholera. He made his friend drive him to a private clinic where he told his doctor that he is experiencing early symptoms of cholera. Within a few hours, he found out that he was simply having a vasovagal reaction.

Still, from then on I was paranoid. I was at war with cholera and I was not about to lose. I found out that not everyone was at risk of catching this disease you know. So, I made sure to follow recommendations. I wanted to be there for my son and I wanted him to healthy and happy.

Zola, who was in middle school at the time, recalled the occurrence of a major stampede triggered by a student’s strident flatulence during an ongoing exam. Moonie’s mother became a compulsive cleaner and made everyone take off their shoes and wash their feet before coming in her house. Martha, who relies on public transportation, disclosed that back then, her heartbeat raised before getting in a \textit{kamyonet}.\textsuperscript{20} Not everyone experienced fear with the same intensity. Lou, for instance, who lives in a secluded community and has a private car, mentioned that back then, he was just a little more concerned than usual. Nevertheless, everyone was surrounded and aware of the tense atmosphere of fear.

\textsuperscript{18} A derogatory term to people who defecate often on themselves without control
\textsuperscript{19} Individual of frail appearance.
\textsuperscript{20} Public mean of transportation used by several individuals.
It was impossible to escape the reports on the death tolls of this epidemic: radio, TV, newspapers, conversations, everywhere. Even if you were no at risk, you’re still on your toes. And I think that really played a number on people’s mind. It’s like, will I be next? (John, 16.7)

Some participants, who reported not being terrified, recognized that several individuals in their social circles equated cholera with loss and distress. Such insecurities were alimented by the publication of scientific reports on the progression of the cholera outbreak which quickly grew into a wide spread epidemic. Cholera is a disease with visible sequelae. People were particularly appalled by the rapid physical deterioration of cholera sufferers and the way cadavers were disposed of. Ben elaborated:

In our culture, we are very close to the dead. We even respect the dead more than the living. We treat dead bodies with solemnity and the utmost reverence. During the sendoff ceremony, that is when people gets to bid their adieu to the departed. When people were dropping like flies, bodies were disposed of right away to protect the public’s health. And that itself interfered with that deeply rooted need for closure. People lost it like we saw in Africa.

The medically guided safety measures disrupted certain cultural practices in funerals and made many people ruminate on the notion of the afterlife. Drogo, who is a medical student, added to this point:

I am all about science, facts, measures, and numbers. But when I saw bodies being zipped in these black or white plastic bags at the hospital, I couldn’t help myself and wonder if I would be at peace if that body was mine. Dying like a dog. Would my soul wander the halls without a final embrace from my mom, my dad? And that freaked my out for a while! That panicked everyone in the ward – doctors, nurses, interns, staff. Everyone.

Ponyo, Drogo and Moonie attended funerals in Port-au-Prince and outside of the capital. They all noticed other ways in which cholera related safety measures changed rituals and procedures. Ponyo explained:
Growing up, there used to be a huge bucket with leaves in it for people to wash their hands when they get out of the cemetery. It’s not like serious washing. I don’t even know what it was for now that you asked. I never even thought of it. You just do it because everybody else is. Now, they have big bottles of hand sanitizer. I have to say that it feels odd like I’m missing something without that bucket with the soothing smell of leaves.

Rick and John shared that many places no longer use water basins for baptism or holy water. “I’m not sure if people go in peace if the priest doesn’t use holy water” John mumbled in a contemplative tone. Aside from fearing the disease itself and the experiences that come with that condition, Santia briefly mentioned the fear of being hunted by the dead:

I know some people who dumped their people on streets to die because they didn’t know what to do with them or didn’t have money to care for them. They become so scared after that. They get nightmares; their dead hunt them. That’s why I wouldn’t leave my sister. I took care of her, and now she’s good. I didn’t want her to be a tormented soul. I didn’t want my children to be cursed either.

Based on the participants’ accounts, the fear of cholera itself was alimented by other types of concerns or fears. First is the fear of getting sick. No one wanted to experience this disease with such visible and gruesome symptoms. Second, there is a fear for one’s identity and self-concept. Romain revealed that he managed his condition\textsuperscript{21} for years and appeared “normal” to others – especially non-family members. His identity as a carrier of cholera during the peak of the cholera epidemic was less manageable than that of a mentally challenged individual. According to him, a seropositive individual is less stigmatized than a person who had cholera. In fact, he would have preferred the former to the latter. I found that other individuals (all men) with whom I briefly talked during my explorative outings who also expressed this preference. Having recovered from cholera

\textsuperscript{21} Referring to being mentally challenged
exposed him to implacable experiences of stigma that make it near impossible for him to conceal his health history. Many people perceive him as “being the cholera disease” and he has been able to reverse this situation. Third is the fear of not resting in peace if one’s cadaver is not disposed of in accordance to cultural norms. Last is the fear of being hunted by the unrested spirit of the dead. The fear of cholera gave impetus to various changes in people’s everyday lives.

Making Adjustments to Protect Health and Self

At the height of the cholera epidemic, individuals took certain measures (some described as extreme) for safety and took extra precautions and measures to protect their health. The majority of them reported buying disinfectant in bulk during that time. Lala, a street vendor, sold sanitary products and made some profit. She would buy large containers of liquid or power chlorine in bulk at the Dominican Republic, come back to Port-au-Prince, and pour the content of the large containers into smaller ones for sale. Nowadays, Lala can no longer be part of that market saturated with retail suppliers to meet the local demand. Ponyo admitted that he could not afford hand sanitizer; he brought a small portable hand sanitizer and refilled it with watered down chlorine. Although the majority of his clothes are ruined with chlorine stains, he stated that carrying the disinfectant with him was comforting. Filip, a professor, shared that back then, he bought hand sanitizer in bulk during his trips abroad as Haïti’s market did not provide or produce these types of products.
I went to Walmart and filled my cart with hand sanitizer, alcohol swabs, and hydrogen peroxide. I got some weird looks, but I did not care. I was not about to jeopardize my health for appearances.

People were cautious, terrified of the disease and their behaviors changed accordingly. Some people avoided physical contact at all cost, sharing food, anything that could potentially put them at risk or extend physical proximity. Zola’s school implemented strict policies that forbid all forms of sharing and physical contacts. Administrators installed running water faucets and made students wash their hands before and after recess. Students were only allowed to drink water from the school’s water cooler dispensers with disposable cups. Public places without running water provided buckets of chlorinated water with soaps for handwashing.

Fear surrounding cholera had some repercussions on daily practices. All participants reported that they avoided street food because of cholera. They paid closer attention to food preparation and ensured that all fruits and vegetables are washed with Chlorine water prior to use. Nadia, a teenager at the time, explained:

I love, love, love fried anything. Before the epidemic, I would buy hot dogs, fried dough, or *papita* for pleasure. When cholera was rampant, to my chagrin, I avoided all street food.

Pete, a case manager, had a similar experience. Unlike Nadia, he mostly bought fruits on the street.

I don’t care for fried food. I usually buy mangoes, sugar canes, anything fruit off the street. They more expensive and don’t have higher quality in supermarkets. When cholera was hitting hard, I stopped buying sugar canes. For the other fruits, I made sure that they were washed with chlorine water. I still do.

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22 Fried plantain
Participants also paid attention to others’ comportments and lifestyle during the epidemic. Varice fired his maid for repeatedly leaving food exposed on the dining table. He made sure to train his new maid himself to ensure that she followed key hygiene guidelines. He monitored sanitation supplies so they never run out. Marie, who was a full time maid at the time, got fired by her employer for “looking” like she had cholera. Marie explains:

Things got harder back then. People wanted to only hire to wash their clothes. I couldn’t leave my job and it wasn’t even paying well. I had problems, so I lost weight. I didn’t notice how much until madam fired me for looking like I have cholera. I was scrawny, I wore the same clothes often because I don’t have a lot….so I got fired. Living in poverty means having cholera I guess.

People also paid more attention to the quality of the drinking water they consumed. All participants reported that they made more efforts than usual to acquire purified water from water purveyors. From my observations, private businesses specializing in the sale of water treatment are noticeable throughout the city. All participants shared that, especially before the earthquake, they did not really worry as much about clean water. Participants who had been to displacement camps after the earthquake reported that the cease of free potable water distribution was one of the main reason that motivated them to move out – even if the living conditions in the other places they could afford was as equally execrable. Having a door to close, a roof over their head, nearby water purveyors were their top priorities. Gary, who used to live in the region where the majority of the residents have wells made a distinction:
People who live in *La Plaine*\(^{23}\) probably didn’t even notice any changes. When I lived there, I had to buy drinking water because a neighbor’s latrine might be connected to the aquifer underground. I didn’t want to risk it. So I used to buy drinking water like everyone else and treated the well water with Clorox for other uses. In places where there are no wells, things might be different.

From the participants’ accounts, practices related to water management varied by zones. Marj, who lives in Carrefour, always had a water faucet and an underground reservoir in her house. Before the epidemic, she treated the water occasionally and used it for everything – including drinking. She used to drink water straight out of the faucet. After the earthquake, especially with the epidemic, she diligently treated water for everyday usage and bought drinking water separately. From the residents’ account, Carrefour does not experience water shortage. Pete and Lala also live in Carrefour. Their apartments are equipped with functioning water faucets. In terms of adjustments, they simply brought drinking water. Rick, Kately and Bob, who live near downtown Port-au-Prince in apartment complexes, have water faucets available to them. The frequency with which water is supplied has always varied – it tends to be less frequent during the summer. It is part of their practice to buy untreated water for everyday use. With the epidemic, they have to buy treated water, as the quality of the untreated water to which they are accustomed is poor. The same applies to Sofia, Magdala, and Tamaraka, who live in Delmas where water is not frequently supplied. From my outings, I found out that the government does not methodically regulate the purified or treated water. A few participants have witnessed purveyors’ questionable practices: advertising chlorinated

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\(^{23}\) Valley outside of Port-au-Prince. Many residents use wells as their primary source of water.
water for purified water, mixing purified water with untreated water in reservoirs, etc. For that reason, many people tend to be critical of the water industry.

One year, there was some problem and DINEPA\(^{24}\) didn’t give us water for an entire month. We either bought buckets of water from neighbors who ordered truck deliveries to fill their reservoirs, or filled out our buckets for $5 [25 Haitian Gourdes] from the place that sells water down the street. I mean sometimes the neighbors give us free water, but when it’s dry season, everyone asks them. So, they sell it and some of them double the price. With cholera, we could no longer drink the water we use to shower and do laundry. So, when we can afford it, we bought a separate water to drink. That’s expensive! (Sofia)

For people who have no faucets, wells, or reservoirs, they buy empty containers like buckets, gallons and tanks to store water. Marie, Manouchka, and Santia live in slums. When they run out of water, they buy it and manually carry it in buckets back and forth until their tanks are filled in their houses. Unlike before the epidemic, people diligently treated all water supplies. For a while, buying drinking water brought some piece of mind to the participants. The price of water varies by company, and each participant had a distinct budget. During my observational outings, I inquired about water prices (see Appendix F, p. 127). Additionally, participants used different methods to treat water if they do not purchase purified water. They used flocculants, disinfectant powder or tablets, or chlorine in tablet and liquid form. Participants with tight budgets use raketa\(^{25}\), lemon and salt, or boil the water. Mary clarified:

Not everybody can buy water all the time, let alone fancy water, or disinfecting stuff. When it’s rainy season, I collect rainwater and treat it. Unfortunately, I can’t store it for long…. I don’t always drink good water.

\(^{24}\) National Directorate for Water Supply and Sanitation in the Ministry of Public Works. This is the main public institution in the Haitian water sector.

\(^{25}\) A plant that used for its natural flocculent properties.
I tried buying sachets for a while - God knows I tried. But I have four mouths to feed. Incentivized by an atmosphere of fear, many participants adopted certain measures to protect their health and other aspects of their lives. As explained by Ben, having cholera could lead to a career loss back then, or financial instability. Ben stated:

As a professor and the director of a research center, having a degrading disease like cholera could’ve, and still can I think, blemish the prestige that comes with my positions. A person like me is supposed to know better. People would avoid me. I would have less contracts. I would eventually end up jobless. Why do you think people from the higher classes go through such length to hide the fact that they had cholera? My friend who works at an embassy went into hiding...literally. Faked a family emergency. He didn’t want people to know.

Mary got fired for looking like she had the disease. Romain became a persona non grata in his community for having the disease. Being a maid may not be assigned the same level of prestige as being a professor; however, each individual, regardless of his or her occupation, ran the risk of being stigmatized or facing discrimination related to cholera. For Mary it was a job, for Ben it is the possibility of losing his job and prestige. Gary pointed out the same trend. As a professor, he mentioned that in addition to potentially losing a job or the prestige assigned to his position, his students and his colleagues would lose respect for him if he had cholera. Lily and Rasta both admitted that they would definitely lose respect for their professors if they found out that they had cholera. All six students echoed this idea. Interestingly, it is different the other way around. All four professors pointed out that a student who had cholera would be less stigmatized than a professor who had the same condition, and that has a lot to do with differences in “power” between the two groups or individuals’ social and economic positions. From the stories, many, if not all, the participants underscored that in Haïti individuals are treated differently based on their position in - what I identified as – social
and economic categories, as well as occupational prestige, net of health status. This difference is illustrated by the popular adage “tout moun se moun, tout moun pa menm.” These factors played a role in the level of stigma, derision, or suspicions related to cholera directed towards certain groups of people regardless of individuals’ health status. These factors are also relevant in interactions between individuals from different social and economic categories. When it comes to sufferers and those at risk, participants explained that the position of cholera sufferers and those at risk in social and economic categories influence between and within group interactions. The severity of stigma to which these individuals are exposed varies. Way before the epidemic, the society did not view street vendors, professors, students, and unemployed individuals equally. From participants’ perceptions, the epidemic simply adapted itself to that structure and that in turn influenced the effects of attitudes related to cholera.

Some health care professionals currently face a degree of stigma regardless of their health status. At the peak of the cholera epidemic, Tamaraka, a nursing student, added that the proximity of medical professionals to cholera sufferers, especially when the epidemic just started, made others stigmatize them less – they were viewed as being “brave.” Nevertheless, such benefits waned over time with the establishment of basic structures for the care of cholera patients and the implementation of cholera training in the curricula of certain health programs. With a relative control over the epidemic, the impacts of stigma and discrimination related to cholera toward medical professionals varied by power, and individuals’ position in social and economic categories. Drogo, a medical intern clarified:

26 In English: Everybody is a person, but not everyone is the same.
Being a doctor is prestigious in the eyes of everyone. Now a doctor who is not necessary from the high class, or have money, could have a large patient base, making him very powerful and respected in the hospital. He can’t be touched, he’s a *bad negro*!\(^{27}\) Patients and colleagues alike might respect a doctor because he is from a good family, or is light skinned, or drives a good car, studied abroad, or because he’s really smart. If you’re from the working class, you may be respected because you have a family member abroad who sends you fancy things and money. Compare to nurses, doctors are treated better. Among nurses, there are differences too. If you have something or are a way that is valued in the society, you’ll benefit from it: money, car, house, connections, physical features […] Many of these things are determined by the way people see you. That’s it. It was like that then and it’s like that now. The chaos just melted in it. None of us would be treated softly for getting cholera because by now, we should know better.

I also found that the level of stigma toward cholera sufferers varies by skin color.

Moonie explained:

If you’re poor, it not a surprise if you get cholera. It’s even expected for poor people to get cholera. When you look at TV, pamphlets, those who have cholera are skinny, poor, dirty and…I’m not narrow-minded or anything but It’s the true…these people have darker skin color. I haven’t seeing any light skin person with cholera on TV.

Santia, whose sister recovered from cholera, was slightly stigmatized by some people in her social circle at church. She still got invited to prayer sessions and her prayer group still shared Sunday meals with her. She did not experience any severe social exclusion or threats. She reported the following:

Honestly, I don’t get it. I’m a *grimel*.\(^{28}\) Look at my wavy hair. I didn’t even get cholera. Sometimes they still call me cholera. Maybe if I got enough money, I’d have new clothes to wear and other expensive things. I’m not complaining. I know I don’t look like cholera. It’s only if someone tells you that you would know that I had cholera…But I didn’t…I think if we were dark, people would’ve treated us worst.

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\(^{27}\) In creole: neg la move. A way to express how powerful and untouchable the doctor is; does not have a racial connotation.

\(^{28}\) A very light-skinned individual. Informal: yellow bone.
Based on the participants’ account, typical cholera sufferers are assumed to more likely have a darker skin complexation. This person is also thought to be uneducated, poor, jobless, ugly, and is more likely to reside in a slum. Given these negative connotations, many of the participants dreaded catching the disease or being associated with it. From my findings, the gruesome physiological outcomes of the disease are among a list of social and economic factors that engendered and nurtured this fear of cholera. People especially feared the weighty social repercussions of this disease: being stigmatized and discriminated against.

The cholera incidence rates attributed deaths exploded in the Artibonite region and quickly spread to the rest of the country to become an epidemic. The highly televised macabre scenery of cadavers abandoned on streets of Port-au-Prince, and the helpless and dried up bodies of cholera patients in overcrowded hospitals fueled the fear of cholera. The fear of being stigmatized and discriminated against drove this sentiment as well. Accordingly, people changed the way they behaved, ate and did their best to protect their health – and their self. As they became vigilant, they held dearly to their health to avoid the disastrous repercussions of this disease that go beyond lying half-naked on a hospital bed with no control over one’s sphincter and gag reflex. From the participants’ accounts, the epidemic blended into the socio-economic reality of the country, and impacted individuals differently based on the following factors: occupational prestige, power, and position in social and economic categories. These variations are pertinent within and between groups.

**Time Passed**

**Facing Challenges to Maintain Safety Measures**
Do you know that story with a guy whose wings made of candle wax melted because he got too close to the sun? That was me with the over the over the top safety practices. They were hard to maintain and I was burning myself out. (Manou)

As time went by, the odds of dying of cholera significantly decreased in parts of the capital. Participants reported seeing more cholera treatment centers, hearing about vaccination campaigns and health promotion in the capital. Moonie used to witness people die on the streets:

I dreaded streets near the hospital after school. You’d always see lines of sick people vomiting and what not. Some dying while waiting to get in. Then slowly the streets looked less like death valleys. My cousin works at the general hospital and she used to get horrible migraines from the chlorine’s smell. She lost her appetite, she used to have nightmares. That cholera chaos stressed her a lot. We were worried about her. When cholera center treatments were being built for cholera patients only, that was a great thing! I know my cousin started living again. She slowly became less hysterical.

The majority of the participants reported that the overall frenzied conjuncture involving the epidemic settled down. The fear of cholera was quite elevated. Accordingly, people made a series of changes in their practices and their behaviors. Over the years, the burden of these changes became taxing. As fear lessened, many of them found it more difficult to live with the same level of vigilance and alertness as before. They found it more difficult to live up to the standard of living they set to protect their health as the level of fear propelled by the epidemic was dissipating. Additionally, they all faced certain challenges that gradually deterred them from living up to these expectations and pushed them to reassess certain practices they adopted when the cholera outbreak was turning into a wide spread epidemic. The need for a reassessment became more pressing as experts were then predicting that the epidemic would be endemic in Haïti. I categorized the various challenges reported by the participants into five
categories: behavioral, infrastructural and environmental, emotional and physical, and economic.

**Behavioral Challenges**

The fear of cholera was especially pervasive during the periods immediately following its detection. Gnawed with confusion, everyone thought they were at risk of contracting the infectious disease as deaths and transmission cases were vertiginous. All participants reported changing daily behaviors. As the years passed, these changes became a burden as fatality rates dramatically decreased by 2014. Overall, many people in the participants’ social circles no longer perceived cholera to be as lethal and slowly transitioned back to their old habits. Lou explained:

As I got used to no physical contact; oddly, a few people around me started hugging, touching, kissing each other again. Next thing you know; the majority of people I know started behaving like before [the cholera epidemic]. I couldn’t keep avoiding physical contact as it felt like I was pushing others away now. I heard people being called *precious ridicule* for that."

Several participants felt like they had to re-adjust their behaviors as more people around them were slowly reverting to close contact during interpersonal interactions. These changes in the way people interacted with each other seemed to be affected by temporality and the decline of tension that existed during the earlier period of the epidemic. Other participants also reported feeling this pressure or need to re-evaluate their behavior as people in their surrounding changed the way they interact with each other. All of them reported being cognizant that this re-establishment of closeness in daily interactions is probably increasing the risks of transmission. The majority of the

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29 Referring to Moliere’s play the Precious Damsels.
participants admitted that despite this concern, they still revised their proximity to others in daily interactions. Here, one can see first-hand the dynamic process of renegotiating and shaping reality through social interaction. In the participants’ social circles, individuals have a considerable ability to shape what happens in the way people interact with each other over time – from minimal or no close daily contact to close daily contact. Romain, Varice and Lou are the only ones who disclosed their unwillingness to align their behavior to what others find socially acceptable. Romain clarified:

In my neighborhood, I don’t touch anyone. I don’t touch anyone who avoided me when I was sick. I only shake hands with strangers. That’s it for now. My best friend visited me recently to smooth things out. He tried shaking hands, but I felt physically sick to my stomach. I can’t move on so fast.

Varice, who described himself as a bona fide germaphobe, later explained his unwillingness to compromise:

We aren’t out of harm’s reach yet. How do I know that people are keeping up with their hygiene in a country with a sanitation and water infrastructure problem, huh? I don’t care who you are. I consider shaking hands at times but I have this overpowering need to wash my hands right after. I carry a backpack with me now so I have space for two water bottles. One for washing hands, one for drinking. A small hand soap and a hand sanitizer. I hug and kiss my kid only. I don’t give a shit! If I get cholera, I’ll be on my own. So…. the heck with anyone who thinks I’m being odd if I don’t want to cajole them.

Lou, who interacts with many people on a daily basis, pointed that he comprises to a certain extent:

Let me be honest with you, I’m a hypocrite. There are some people I avoid and do my best to just wave at them…you know…people who don’t look... People I suspect are not too keen on the hygiene department. I’m sorry if I offend you. But you’re asking for the truth. This is it. I don’t want to hug someone with dirty clothes, unclean nails, greasy face. People who look questionable. […] Ok fine. Peole who don’t look like me. For work, if I meet with important people, I will shake hands unless they don’t
want that […] that is my work on the line here, I have to play along. That’s it. (Lou. 45.5)

From Lou’s account, it appears that not everyone participates in the process of renegotiating reality with equal standing. In his case, Lou’s level of agency in the process of shaping reality is dependent on other individuals’ occupation in relation to his as a professor, independent consultant, and a business owner.

As a group, the participants recognized that it became challenging to sustain behavior changes when it came to maintaining interpersonal relations. Distancing themselves from others slowly created undesirable friction and possible alienation. Some participants opted to comprise by simply limiting the extent to which they come into close contact with others. While examining the mechanisms through which people reassessed and adjusted their greeting practices vis-à-vis each other, the process of shaping a new reality became alive. The level of individuals’ agency in the negotiation process seemed dependent on their position in comparison to others in social and economic categories. In the example discussed above, occupation is the central hierarchical category.

**Infrastructural and Environmental Challenges**

Participants identified the city’s poor water and sanitation infrastructure as factors that made it difficult for them to adhere to the protective habits they developed during the peak of the epidemic. Martha, a young account, shared her experience:

Not all buildings have running water. I went to a state building and went to the restroom. There was water and no soap. The water tank looked sooo dirty. Let me just say it: I didn’t wash my hands. Using this water seemed riskier than not washing my hands.

Zola, who is a high schooler, noticed a change in his school’s practice that affected him and his classmates:
At first they were very strict. They had water faucets, bar soaps. They monitored us. Later, there was water but no soap. Then the water faucets no longer had running water. Then, there was no water, no soap. Finally, there was a large uncovered water tank with a small cup to fill up to wash hands. The lines could be long, so some students started washing their hands in the tank. By mid-day, that water was filthy that fewer students washed their hands. By the time I transferred to another school, there was nothing. And they made us pay $1 [5 Haitian Gourdes] for the disposable cups to drink from the water dispenser.

Many participants found it challenging to maintain certain hygienic practices outside of their home when a vast number of the public places that they frequent have poor to no water or sanitation infrastructure. Manouchka, who used to sell vegetables on the streets, explained:

The government gave us a building so we would stop selling things on the streets. Those who refused to stay inside had their merchandises seized by the police. How do you expect me to stay in a place with no toilets and running water? They had two bathrooms that didn’t work after one week. And the way that thing was built made it hard for clients to reach us, so we made less money. Many of us decided to stay outside. After a while, the police left us alone.

Santia, who was a street vendor ephemerally, added to this argument:

“If I wasn’t on the streets, I couldn’t bring money home. So I made it work. It’s not always pretty, but what was I to do? I’d get shooed away if I went anywhere and asked to use the bathroom. I just disciplined myself not to shit on the streets. After that, I hustled, ate, pissed on the streets. I can’t talk for everyone. For some people, the streets are home, so they do everything at home.”

Bob, who was part of an investigation on sanitation, observed a similar dynamic in the displacement camps. The displacement camps were not equipped enough to meet the needs of the campers. Either there was not enough water or the toilets were not maintained. That situation often leads to a “shitty” fiasco. He pointed out that there were several attempts to involve the community in maintaining the state of the camp; however, there was a lot of conflict among camp residents who seemed caught up in a cycle of
accusation and counteraccusation for the deteriorating living conditions. Sofia, Magdala, and Tamaraka temporarily lived in displacements camps and highlighted that it was hard to maintain good hygienic practices in camps without necessary structures. Varice who has lived in the capitol his entire life recognized that the issue of poor infrastructure in Port-au-Prince is a plight that existed since the late 50’s. It simply worsened with overcrowding.

Sofia, who admitted being a compulsive cleaner, was frustrated with the way other people treated the public toilets. Although the place where she currently resides is more autonomous, she still runs into the same issue where her neighbors poorly treat their shared bathroom.

You’d be surprised to know that some people didn’t grow up with automatic bathrooms. They’re used to shitting in the woods. I’m so serious! Then all of the sudden they move to a major city, or see a modern bathroom for the first time. How do you expect them to treat a bathroom? I’ve witnessed individuals relieving themselves everywhere but in the toilet bowl. It’s a sensitive issue. A lot of people don’t know how to maintain a bathroom the right way. They need to be educated. But people rather die than admit to that.

Some participants do not have a restroom where they live. Mary shared her experience. She lives in a little house made of one room with her kids. They carry water to the house and store it in different size containers. They cook and bath outside where they divided two sections around the corner of the house with aluminum-foil roofing sheet for privacy. Since they do not have a bathroom, they go in the woods, relieve themselves in a plastic bag and throw it in the nearby ravine.

Most of the neighborhoods do that. If you have the money, you pay someone to dig a hole to build a latrine. If I could, I would give my kids a latrine. But I can’t. Some neighbors, once they get the latrine, they look
down upon people like me who do *helicopters*. They forget they used to do that. I know it’s bad, but I do what I can. When it raining, it goes away…(Marie)

John, who drives all-round the city on a daily basis, identified the same problem. The lack of water infrastructure makes it more challenging to adhere to hygienic practices like frequent hand wash. Facing this issue has been such a burden for him that he resigned himself to be at peace with not following certain hygiene guidelines. Furthermore, when it rains, depending on where he goes, he prefers staying in his car as the streets tend to be overflown with dirty water, detritus, and *ti karol*.

During times of drought, he admitted that he usually buys several cold beers throughout the day to quench his thirst instead of water since alcohol kills germs. Kately made an effort to keep her apartment clean and threw the trash on a regular basis. In her neighborhood, people usually throw the trash on a designated corner for public sanitation pick up. As the years went by, a pyramid of trash began to occupy the corner as public services become more infrequent. Kately, with the help of some neighbors, resorted to burning their trash to decrease the size of the “pyramid.” Unfortunately, many of her neighbors, who are infuriated and discouraged by the lack of public sanitation services, now dump their trash on the streets. In turn, the trash piles clog the canals and cause sewage water to overflow every time it rains.

Certain infrastructural and environmental conditions are not conducive to the maintenance of good hygienic and sanitation practices. Participants reported that poor water and sanitation infrastructure, inadequate canalization throughout the city, and the infrequent provision of public services stifled efforts at community and individual levels

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30 The circular motion of throwing away a bag full of feces.
31 Tied up sachet with mysterious content that tends to be defecation that were *helicopter*ed into ravines.
to maintain a safe environment. In cases like Kately’s, the connection between macro level challenges and the process of negotiating practices. As they confront issues related to public services, people collective look for alternatives them. At an individual level, decisions to partake in these collective efforts vary. Many of the participants admitted committing certain negligence or relaxing their strict hygienic practices as the years passed by.

**Emotional and Physical Challenges**

The emotional and physical toll of cholera epidemic incited individuals to reassess practices acquired at the peak of the epidemic. First, the frequent use of water treatments, disinfectants affected the health of some the participants over time. Many participants experienced skin irritation, skin discoloration, headaches, upset stomach, and nausea with the used of these chemicals. Magdala, who has been managing a chronic illness her entire life, shared:

> We used to drench everything is Clorox. Slowly, I noticed that my migraines got worst. Look at my hands [apparent skin damage with patches]. I got it from using bleach too much. So we use less bleach now. Sometimes, we avoid bleach for days and use lemon instead.

Some participants experienced stomachaches and nausea after drinking treated water. Mary, Manouchka, Santia, Dax, Manou, Tamaraka, Sofia, Magdala, Lala, and Ponyo primarily rely on treating water for drinking. All of them found the chlorine-based products to leave an unpleasant after-taste in the drinking water. They all experience a subtle pain in their stomach or their solar plexus region after drinking the treated water. Furthermore, these products do not seem to stop a worm-like water parasite from growing in the water. Santia gave some details on that matter:
We are told to treat the water with these tablets that make the water smell and taste like Clorox. If water is treated, how come those worms come up in the water after a few days?

In the absence of potable water, participants who rely on treated water to drink opt to boil it instead. They feel as if the chemically treated water is slowly poisoning them.

Ponyo added:

We’re getting sick because of water contaminated by white people’s shit. Now, we have to buy water. If we can’t, then they gave us a bunch of crap to treat it. Now we are getting sick from it. I can’t drink water straight from my faucet like I used to because there’s either dirt in it or they’re some tiny z shaped living thing in it. All this and the government is still absent leaving NGOs to lie to us and treat us badly. I grew tired after a while. We get the water from the faucet. We boil it if it’s for drinking, add Clorox for other uses. I got so tired. I just don’t think about it anymore.

All participants used treated water for non-drinking tasks such as showering and doing laundry. Some of them purchased purified water for extra precaution. For example, some participants opted to brush their teeth with purified water since they could afford it.

In these instances, they used purified water for a few non-drinking related tasks (i.e. making tea or coffee) to reduce their risks of exposure to polluted water. All participants made an effort to buy purified water for daily consumption. As the years passed, some of them could no longer carry the burden of exclusively buying water to drink, so they resorted to treating the natural resource with water treatment products. Some participants admitted that they do not trust the water treatment products as some of them make them “feel abnormal.” Two participants stopped using these products altogether after hearing rumors of people dying from them. The physical toll of these products on some of the participants deterred them from using them regularly.
Emotionally, some participants shared that the cholera epidemic, especially at its initial stage, created a distance between Haitians. Ben shared:

After the earthquake, there was a collective understanding that we needed each other: togetherness. Several reports showed that there was an increase in social support within many communities after the natural disaster. Then bam! Cholera came and created a distance between members of this society while the mourning process was still ongoing. We [scientists] have not even weeded out a threat in this mess.

Before the epidemic, many participants recognized the overall need for togetherness in the country. It was a message circulated by the media, person to person, everywhere. With the fear of cholera, many people distanced themselves from each other. This phenomenon was pervasive everywhere at the beginning of the outbreak, especially in families, as household members were the first ones to be in contact with the sick. Some participants alluded to prevention messages on TV and the radio encouraging people to maintain a safe distance from others and limit physical contact. John, who is an avid churchgoer, was marked by being unable to give the kiss of peace to his fellow churchgoers:

We had church members who died during the earthquake and all I wanted to do is console the survivors…but I couldn’t! I couldn’t even give the kiss of peace. I’d avoid that part by pretending to go to the bathroom. My work depends on my health and I couldn’t risk that. That didn’t leave me feeling good though. I felt tormented for a while. I started going to church less often. Hm hm. I am a man so I dealt with it. My late mother couldn’t take it. I think her broken heart is what hastened her death. (John, 25. 2)

Other participants limited their involvement in social activities to reduce the risk of cholera exposure. Gary stopped going to the restaurants with his friends. He explained that no one openly discussed the sudden halt in frequent interactions. As a result, many
friendships and social bonds rusted. Ben, who visited the outskirt of the capital for research purposes explained:

Because of this contract, I had to travel to the South to gather data on people’s behavioral changes pertaining to water treatments. In the rural areas, people are different. The primary, pain free, way to establish a rapport with members of some communities is by sharing a meal and drinking from a bottle of tafia\textsuperscript{32} that is passed around. On day one, I managed to avoid that step and my interviews suffered. I could tell that participants were visibly uncomfortable and their responses were stale. I knew I messed up and that pained me. Oh the pain! Then, a member of my team had cholera our last day on the field. I’ll let you guess how I felt.

The cholera epidemic attenuated the solidarity engendered from the tragedies of the earthquake and created a physical and social distance among individuals in the Haïti population. As people became concerned with the transmission of cholera and the protection of their health, they minimized close interactions. As time passed, many participants reported feeling either uncomfortable or chagrined by this distance or knew people affected by it. As the lethality and unfamiliarity of the cholera dissipated, more people reevaluated the importance of these isolating measured which were emotionally taxing at various degrees.

The meaning of close contact derived from social interactions among individuals from various social circles. In John’s church, it was a way to convey peace among members of the congregation. The meaning assigned to close contact changed over time with the upsurge of cholera cases. Prior to the population’s overall awareness of cholera’s life cycle and mode of transmission, close contact was interpreted as a mean of cholera transmission, hence minimized or discarded in some cases. Over time, with increased awareness, the fear of the disease and its lethality decreased. Similarly, the change in the

\textsuperscript{32} Raw rhum.
epidemiological context influenced many people’s perceptions. Gradually, the meaning people assigned to close contact altered through an interpretative process - ascertaining the meaning of others’ actions.

**Economic Challenges**

Participants, especially unemployed and underemployed, faced a series of economic hardships that made it difficult to maintain proper hygienic and sanitation practices to prevent a cholera infection. Many participants reported being burdened by the cost of preventive measures. Additionally, many of them were living in conditions of poverty that are stagnant and seem unsurmountable. Mary explained:

> I was *bat dlo pou fe be*\(^{33}\) then the epidemic made things harder. I had to worry about cholera now…Water, wash hands, trash, kid, health [sigh]. I tried, but I wasn’t being paid well. I used the transportation money to buy drinking water now. Then the boss reduced my pay. I woke up early and walked from Debussy to Petionville [about 7 miles back and forth] every day often on an empty stomach. Madam doesn’t always give me left overs. When I get them, I save them for my kids. I got scrawny quickly. Then around 2012, the boss fired me because I looked like I had cholera. I had better things to worry about than cholera. When your kids could be on the streets, when you depend on your neighbors’ charity for a piece of bread…You don’t care about a lot of things, water quality included.

Some participants mentioned facing the increasing unbearable burden related to purchasing water and disinfectants at different levels. Only six participants experienced no economic challenges. They had the means to meet the demands that came with the epidemic beforehand. Others reported worrying about costs, as they strategize in order to stay afloat financially. All unemployed and underemployed nondependent participants reported that they could not always afford treated water or sanitation products. As time

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\(^{33}\) Churning water to make butter. It could also mean to make something worthwhile out of almost nothing.
went by, they had to choose between clean water and other expenses like food, shelter, or school tuition. Rick explained:

“Buying drinking water and buying regular water for other uses isn’t a game. I had people tell me that buying clean water is affordable – not when you’re paid 200 Haitians Gourdes [around 3.33 USD] per day. People don’t live off air. Unfortunately, that is the reality of a lot of people in Haiti.”

Nadia’s comments were parallel to that of Rick’s:

I lost everything during the earthquake. I was on the street with my sister. Cholera came [shrugs]. Like many of my friends, I started offering pleasure for pay to survive. It’s not something that I’m proud of, but I’m not on the streets anymore. At least now, my sister can go to a public school, and we’re not living under a tent. Things are still tough and we have nobody to count on. If I worry too much about cholera, I won’t live. Mikrob pa touye Ayisyen.34

Grimaud and Legagneur (2011) and Williams et al. (2015) both found that people in certain Haitian communities used the expression “microbes don’t kill Haitians” to convey the disbelief that unsafe water or microbes pose a threat to their health. The years in which the researchers conducted these analyses fall within the temporal category that I define as the peak of the cholera epidemic. As the years passed by, as the cholera fatality rate decreased, I found that this expression took on an additional meaning given the slight change of context in the circumstances surrounding the epidemic. For some participants in this study, this expression was not solely limited to conveying disbelief. It was also a way of conveying resignation. Manoushka explained:

It’s not like I don’t believe that I can’t get sick from cholera or if I drink bad water nothing will happen. For me, it is a way to tell myself that I have so much that I go through, there are so many others microbes that I’m exposed to, it’s a miracle I’m even here and there’s a reason for that. I have no choice but to live, whatever it takes. If I start thinking about what

34 Microbes don’t kill Haitians.
goes in my body every time I put something in my mouth… I’ll be miserable. So, *Mikrob pa touye Ayisyen*.

Lala, Mary, Sophia, Magdala, John, Dax, Rick, and Santia reported similar details. They all clarified in their own words that this expression conveys resignation, almost like a copying mechanism, something people say to give courage to themselves when faced with the grim reality of being unable to make certain choices or changes such as buying quality water or ameliorating their living conditions. Dax shared:

> If I spend an entire day hustling on the streets, I eat there, I do my deeds, and drink whatever water I can find. I don’t wash my hands as much as I’d like. When things were bad, I tried eating home food, and brought treated water with me. Water’s never enough; the food goes bad. I don’t have a fridge. I can’t always buy charcoal for cooking. It costs me more! With 15 Haitian Gourdes [25 US Cents] I can buy a big *pate* and a *zo blode* for 5 Haitian Gourdes [0.1 US Cents] or buy 3 sachets of water. On a good day if a *neg* give me a hand, I get myself a good juice. I can’t add more problems that what I have, otherwise, I won’t live. (Dax, 15.13)

The previous connotation of disbelief linked to the Haïtian proverb *Mikrob pa touye Ayisyen* during the peak of the cholera epidemic is not obsolete. It still exists and is fueled by a degree of skepticism vis-à-vis the way cholera awareness messages are formulated. Martha, who is an avid radio listener and newspaper reader, questioned the veracity of the prevention messages in the cholera awareness ads. She pointed out:

> “There are so many crazy people roaming the streets of Port-au-Prince. They are so filthy! Some of them barely have clothes on. They talk to themselves, they drink from the canals, they eat from the piles of trash – maybe shit too. How come THEY don’t have cholera if you can get it by living like that? It’s common to think that only a *melere* can get cholera. I mean the way cholera is known now, it’s like it’s caused by living in bad conditions. How are we supposed to stop living like pigs if no one is

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35 Fried dough stuffed with one hot dog and 1 boiled egg or 2 boiled eggs with cabbage or other meat.
36 A sachet of juice.
37 In English: Negro. In Haitian context, a term of endearment for loved ones, friends, or close acquaintances.
38 Extremely poor person.
helping us? Not even the government cares. There are places where trash is never picked up, or there’s no water. Politicians come and make promises for votes, and then you never see them again when they win. NGO’s come with their blan, make a bunch of fuss, take pictures, then go. In a country where the majority of us are churning water to make butter, living like dogs, why don’t we ALL get cholera? Why are we blamed for a situation we can’t change? So of course, some of us choose to believe that this disease can’t kill us. We know it’s a disease, but we can’t help people blame us for it. We leave it all to God.”

Some of the participants living in impoverished neighborhoods have underscored the role of current cholera awareness campaigns on community members’ attitudes. Based on their accounts, strategies used in cholera awareness campaigns and education programs seem to put more emphasis on community members’ ability to prevent outbreaks while passing on the impacts of structural level forces on the stagnations of the precarious living conditions in communities. Santya elaborated:

These people came with little papers showing how to wash hands and treat water. They tell us: ‘pooping outside isn’t good, drinking untreated water isn’t good, storing water for too long isn’t good.’ What else should we do? It’s almost like it’s our fault that some of us live like this. Like we make it easy to get cholera. If we stop dumping trash in the ravine, or stop pooping outside, what else are we going to do that? We know it’s bad, but there’s nothing else to do. The government doesn’t help us. Only God looks after us, so I leave everything to him. We try. We help each other out to make things less bad, but it’s not always enough. In the end, mikrob pa touye Ayisyen. (Santia, 33.9)

The way Santia uses the Haïtian adage above is in line with Grimaud and Legagneur’s field report (2011) about the Haïtian expression Mikrob pa touye Ayisyen being used by members in certain communities to indicate that no microbes can kill them given their execrable living conditions. There is a contextual difference given the time of the data collection of each study. During the time of data collection for this thesis, Haïtians are no longer confused about the origin of cholera. This belief of apparent invincibility toward cholera seems to be in response to what many individuals in certain
communities perceive as blaming certain groups whose living conditions are risks for cholera.

Many participants are parts of certain geographically unbounded networks on which they rely for social, professional, financial support. From my findings, these networks vary by the nature of the sought support and can have two types of dynamics: unilateral and bilateral. Many participants utilized them as mechanisms of subsistence. Kately shared:

My mom sent me and my sister to the capital to further our education. She helps us with rent and other expenses the best she can. It is tough to make ends meet while neither of us work. Sometimes, we don’t even have money to buy water to cook or take a shower. When push comes to shove, which is often, I go to my godfather for help. He lives overseas and help us whenever he can by sending money transfers. My mom looked after his kids when he emigrated until he sent for them. We have history. Nevertheless, I am embarrassed to keep asking, but I don’t have other options. For food, I go to my aunt [a street vendor] who give us with leftovers so we don’t starve.

Other participants like Sofia, Magdala, and Rick reported counting on friends and family members in the Haïtian diaspora and other parts of the country for financial support. Based on accounts, this type of network has an overall unilateral dynamic in which individuals count on one or a number of other individuals for financial support or the provision of other non-monetary resources (i.e. For Mary, it is food; for Dax and Ponyo, it is odd job opportunities; for Kately, Sofia, and Magdala, it is remittance). The dynamic of these types of social networks varies in size and can be bilateral or multilateral as well. In this sense, actors share their resources with each other and provide support to each other. For instance, in Manouchka’s neighborhood, members of the same church form groups in which they pray at each other’s house, share food and other resources with each other. Manouchka described:
I pray for you when you need it, you do the same for me. I cook the beans, you cook the rice and we share it among ourselves. You give me water when I don’t have any, I do the same when it’s my turn. I help you care for your sick and you do the same for me. If you’re closer to the water pump than me and I have more containers than you, we make it work. If we live near each other, we keep our places clean. If we live far, we share cleaning products. I can borrow money from you to buy water. I live far from the hospitals, and there are no clinics around. If you’re a nurse or doctor who lives nearby, I go to you for medical things and I provide you services or favors. We help each other breathe.

When Santia’s sister was released from the hospital, her large network of churchgoers provided spiritual, financial and emotional support during a long period of convalescence. Romain’s family constitutes a smaller network that supported him emotionally and medically while he recovered from cholera. Based on my findings, these types of networks seem to be common among church members and students. Some participants like Sofia and Magdala reported joining a network once the religious community of a local church legitimized their membership. All individuals of that network share common religious values and aim to alleviate the group’s economic struggles. Tamaraka, a nursing student, reported the existence of a similar type of network among some nursing students – especially those who struggle financially. Students forming the network support each other with benefits that accrue from combining their resources. Members do not necessary share common values but seem bonded by informal rules and a common goal: academic success.

Based on my findings, I would argue that unilateral dynamics are most likely to occur within a vertical structure among members given their dissimilar positions in the same or different social and economic categories. These social ties tend to occur among family members, close friends, or close acquaintances that experienced upward mobility. Bilateral or multilateral dynamics tend to occur within horizontal, or near horizontal,
structures among members in similar social and economic categories. From these experiences, I identified the presence of a primary and a secondary characteristic that links members of networks. Going back to Mary’s experience with defecation practices, she highlighted that in her network – which she refers to as her group, people do not have access to sanitation infrastructure (primary characteristic); they share common geographical location and struggle financially (secondary characteristics). Acquiring a latrine (the primary common denominator) represents a change of status. As such, proprietors of the valued commodity experience a rupture with an old widespread practice, leave the network to form or join another group where members share a different primary characteristic. Some participants are able to adapt to the epidemic and maintain ad hoc adjustments through use of the social networks described above. In the context of multilateral dynamics, these social networks could be regarded as social structures built by individuals to secure benefits through the means of mutual aid.

At a societal level, based on participants’ accounts, economically disadvantaged groups are currently blamed for not changing their living conditions to help the epidemic. Economic struggle, grinding poverty, and low quality of life are all part of the social reality of groups blamed for the epidemic and appear to influence the way these individuals perceive cholera. Based on the accounts of some participants, the macro level dynamic seems to influence the use of alternative meaning frameworks, other than the scientific, to make sense of the disease and the epidemic. Based on my findings, addressing the cholera epidemic within the scientific framework recommends addressing risks factors (i.e. build bathroom or have access to running water) which are enmeshed in one key aspect of the social reality of these individuals: poverty. Furthermore, within the
scientific framework, the society seems to overestimate the ability of individuals to change their execrable living conditions. I posit that the use of alternative frameworks to make sense of cholera could be either a coping mechanism or a response to a nexus between societal blame, agency overestimation, and stagnation of poverty. Since treating cholera as a disease, within the biomedical framework, insinuates effectively addressing risk factors and making a rupture with their social reality, many individuals – either blamed for the epidemic or stigmatized for having the disease – use alternative frameworks (religious or mystical) that diffuse the blame and relatively dissociate them as potential influencing factors actors.

Economic hardships made it difficult for some participants to maintain standards of living to protect their health at the beginning of the epidemic. For those who have been struggling to make ends meet prior to the cholera outbreak, the burden of cholera prevention became financially taxing. If individuals are part of significant social networks or have no financial means to make necessary changes or ameliorate their living conditions, they go back to their pre-cholera habits and practices. These habits and practices, coupled with the insalubrious environments increase their risk of exposure and are favorable to cholera outbreaks. Here, through a symbolic interactionist’s lens, I was able to draw a connection between the micro level (the way people do things and think) and macro and structural level issues (poverty, quality of life etc.).

**Post-Peak of Cholera Epidemic**

**Adapting to the cholera epidemic**

Although the prevalence of cholera and case fatality rate escalated at different periods, six years after the cholera outbreak, all of the participants reported that living in
the midst of the epidemic is the new normal. The majority of them thought that the worst is behind them. As many of them pointed out, the biology of the pathogen and the etiology of the disease are well known in the capital. At the height of the epidemic, Haïtians took necessary measures to protect themselves. They limited physical contact with others, watched what they drank, what they ate, where they ate, and maintained their environment as cleanly as possible. Like martinets, many participants insisted on meeting the highest hygienic and sanitation standards of living. As time went by, the tension and fear of cholera relatively decreased with lower cholera related deaths and case fatality rates. At the same time, many participants found it more difficult to adhere to the standard of the protective measures they set at the height of fear of cholera. This realization led them to reassess the changes adopted during the peak of the epidemic to protect their health. Participants reported different levels of adaptation to the epidemic.

Gary admitted:

“Cholera is almost like a norm nowadays and you hear cases mostly outside of the capital or during rainy seasons. So, it’s not putting as much pressure on us as before. The media doesn’t pay as much attention to it either. They no longer do that psychological overkill where they make it seem like cholera is like a scary filthy monster hiding behind doors ready to pounce on you.”

Some of them are no longer concerned with contracting the disease. They protect their health and remain informed on the evolution of the epidemic. Marj clarified:

There’s nothing to fear. I know what to do. I know that scientists have determined the number of microbe to ingest that can make you sick. With my lifestyle, it’s near impossible to get this disease.

Other participants added that knowledge was not the only factor to protect one’s health against cholera. Sixty percent of the participants admitted following the guidelines to prevent cholera is contingent on one’s means. It was a common understanding that
those without sufficient means are more at risk of catching the disease as they are not able to afford living up to the health safety standards to prevent cholera. Martha clarified:

“There are slums almost everywhere even in the nicer parts of Port-au-Prince. So it’s hard to say where you live can help protect you. Some parts have more people with money, they can pay private companies to provide public services. If there’s no water, they buy it. If the trash is not picked up, they pay for that to happen. No electricity, they have inverters. Now if you live in their vicinity, you benefit from that. One street over, there are people who can manage, and further down, there are poor people who have no choice but to dump trash near the corner or don’t have bathrooms. Those who have money build walls and keep the filth away from their nose, their eyes, and their mind.”

Members of certain communities, especially the economically disadvantaged communities, rely on their social networks to have the minimum (clean water) in their lives. Based on the findings, all participants viewed the epidemic as a new facet of the Haitian reality and felt obligated to modify their lifestyle according to this public health issue. Each participant has adapted differently. The epidemic is an afterthought for Lou, Gary, Marj and Ben as opposed to Varice and Romain who still feel uneasy living in the midst of a cholera epidemic and remain concerned with the possibility of catching cholera. Filip is no longer scared of getting the disease. As he remains careful, he is confident that his lifestyle is not conducive to such predicament. Mary and Nadia are too preoccupied by their financial struggle to worry about water quality. They are aware of the risks of getting cholera, but they live life one day at a time with the “protection of God” in the absence of significant social networks in their lives. Individuals struggling financially seemed more preoccupied by subsisting. To them, cholera was just an iota on the pile of problems they face on a daily basis. If they do not have any significant social network to help them navigate these worries and meet the minimum standard to protect their health, individuals resign themselves to go back to old habits and practices that pose
a potential threat to their lives. Zola and Moonie who are considered dependent in the Haïtian context, did not seem to worry about the epidemic. While Zola is preoccupied about gathering the courage to ask a girl out, Moonie is apprehensive about driving her mother’s car and getting to a good college.

**Process of Adaptation Amidst the Ongoing Cholera Epidemic**

Grounded theory goes beyond the mere description of phenomena and aims to develop a theory that is grounded in experiences of participants. Based on the findings of this study, I identified a process that fits into the lives of participants in regards to their adaptation to the cholera epidemic shaped by the perspectives of the study participants. The symbolic interaction perspective used in this study allowed for description of changing behaviors and practices through processes of negotiation and interpretation as well as the epidemiological evolution of the epidemic.

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**Figure 2 – The Process of Adaptation Amidst the Ongoing Cholera Epidemic**
The conjuncture involving the epidemic through time evolved in three periods: pre-cholera epidemic or post-earthquake, peak of cholera epidemic, and post-cholera epidemic or present time. All categories above (Figure 5.2) fit into a period. Before the upsurge of cholera case in the Artibonite region, there were no changes related to cholera. In fact, as many participants shared, this disease was unknown and exterior to the population’s reality. Toward the end of 2010, an outbreak of cholera occurred in Artibonite and quickly spread throughout the rest of Haïti. In response to the atmosphere of fear fueled by the skyrocketing death tolls, people made a series of changes (in some case drastic) to protect their health. As time passed by, the spread of epidemic is decelerated by public health responses. Many people remained vigilant and continued to adhere to strict the protective measures they adopted to protect their health.

As death tolls related to cholera decrease significantly, the fear of cholera slowly diminished. Over time, participants faced a series of challenges that pose a threat to their adherence to perceive measures implemented at the height of the epidemic to protect their heath. These problems prompted the majority of them to reassess these protective
changes. The epidemic was especially tolling on individuals who are unemployed or are underemployed. They struggled to both maintain the standard of living necessary and ameliorate the living conditions to decrease the risks of the emergence of a cholera outbreak.

These challenges prompted people to reassess their adopted practices in relation to the epidemic as well as the reality in which they are living to find equilibrium in their everyday life. After the stage of reassessment, some people make the necessary adjustments and find a new way to align their way of life to recommended guidelines (indicated by the reverse arrow creating a loop).

Individuals who are economically disadvantaged rely on their social networks to maintain a basic continuum in their everyday life and follow cholera prevention guidelines. If they do not have any social networks, they go back to old habits and practices – propitious to the emergence of an outbreak. Based on the findings, the cholera epidemic affected people differently. People who had the financial means, adapted and adhered to cholera prevention guidelines with more ease than individual who struggle financially. Members of this latter group rely on their social networks. Individuals from economically disadvantaged groups seem to rely on their social networks, while individuals with the financial means primarily rely on their wealth and income to meet the financial demands of adhering to cholera preventive measures.

**Summary of Findings**

Symbolic interactionism theoretically focuses on meaning, on the premises that people act based on meanings which are developed in social interaction through
interpretation (Blumer 1969). The interpretation of meanings is a continual and emergent process done through shared language and communication (Charmaz 2014). This study investigated the extent to which the cholera epidemic changed the lives of Haïtians in Port-au-Prince, with a focus on the role of individuals’ social reality in the way they make sense of the epidemic and their mechanisms of adaptations. This study contributes to the nascent literature with two significant findings: identifying of two important means of adaptation to the epidemic and connecting micro and macro level factors from the perspective of laypeople.

The cholera epidemic, especially at its peak, has impacted the lives of people living in Port-au-Prince in numerous ways. While recovering from the aftermaths of the 2010 earthquake, Haïtians were hit by the impact of the cholera outbreak that rapidly turns into an epidemic. The high death tolls drove feelings of fears that prompted the population to become hyper vigilant and create a social distance among individuals. Many people changed their lifestyle and adopted a series of strict measures to protect their health from the disease. As time passed by, the threat and fear of cholera diminished as the medical body better managed the epidemic. People continuously reevaluated and attuned their extra cautious attitudes to the new conjuncture and their lifestyle. Adapting to the epidemic and the magnitude with which this public health problem impacts individuals depend on individuals’ financial means or their social networks. In the absence of both resources, people go back to old practices, common before the emergence of the epidemic, that expose them to risks of cholera.

The findings of the study demonstrate that even in the midst of a devastating epidemic people actively interpret and construct the meanings of their reality. Findings
also show that symbolic interactionism can be used to outline macro level factors from a micro level analysis. The use of alternative frameworks to make sense of cholera could be either a coping mechanism or a response to a nexus between societal blame, agency overestimation, and stagnation of poverty. Since treating cholera as a disease, within the biomedical framework, insinuates effectively addressing risks factors and making a rupture with their social reality, many individuals – either blamed for the perpetuation of the epidemic or stigmatized for having the disease – use alternative frameworks (religious or mystical) that diffuse the blame and relatively dissociate them as causal elements. These trends seem vary by ones’ positions within social and economic categories.

Presenting cholera as a disease of poverty in a country gnawed by widespread poverty and a historical lack of water and sanitation infrastructure appear to influence how people see cholera.
Chapter 6: Conclusion

Findings Placed Within the Context of the Literature

People were just reaching a point of relative equilibrium post-earthquake when the cholera epidemic fissured their newly found social order. The epidemic disrupted assumptions about interaction, severed social structures, and created a distance among Haitians through the means of language. My findings suggest that the fear associated with cholera did not emerge on its own; it seems connected to the natural disaster that occurred earlier that same year. During that time, Pat Robertson, a conservative American religious figure, overtly blamed Haiti’s Earthquake on a pact Haitians made with the devil during the Bois-Caiman vodou ceremony of August 14th 1793 (the onset of the Haitian revolution) to break free of the French in the 1700’s (TheYoungTurks 2010). According to participants, this comment echoed in many communities and petrified the population already in a fragile state. The fear of cholera amalgamated with the earthquake’s ideologies based on fear and seemed to have created a solid platform for the biblical context from which some cholera explanations originate.

Stigma and Fear of Stigma

The atmosphere of fear especially at the peak of the cholera epidemic, facilitate an outbreak of social stigma that impacted different groups in the Haitian population. The focus on a particular stigmatized group varied in accordance to what Farmer (1992) calls the ‘cycle of accusation.’ Based on the participants’ accounts, people blamed vodou practitioners for causing cholera. The publication of the epidemiological report confirming the human transmission theory of the cholera outbreak turned MINUSTAH peacekeepers into personae non-gratae. Presently, at a local level, the blame seems
mainly focused on the poor. At an international level, Hamlin stated that the epidemic revived stigma against Haïtians who have a history of being blamed for infectious disease epidemics. Based on my findings, within Haïti, the epidemic locally exacerbated prejudicial and discriminatory attitudes towards the poor who have been a marginalized group in that society (Smith, Gelineau and Seligson 2012). When one has or had cholera, is at a high risk of having cholera, or appears to have cholera, the individual is labeled as a cholera carrier, especially during the peak of the cholera epidemic. Based on the findings, the unmanageability and apparent permanency of this spoiled identity alimented the fear of cholera. Although the fear of cholera seems to have decreased since 2010, stigma related to the disease still exists.

In this study, the fear of cholera intensified other fears related to stigmatization, such as fear of being socially marginalized and stigmatized. These circumstances incentivized many individuals to make certain adjustments to lower their risks of having cholera which often times entailed adhering to strict health safety measures. As seen in the accounts of this study’s participants, many people were very aware of the social and economic ramifications of being subject to stigma related to cholera regardless of their position in social and economic spheres. Individuals feared losing their jobs and occupational prestige. As time passed by, these fears decreased.

From a strictly medical perspective, cholera only thrives in insalubrious environments with poor sanitation and water infrastructures. As time passed by, the medical body became relatively more equipped to manage outbreaks in the capital and more laypeople were educated on the pathology of the disease. This situation seemed to have contributed in the decrease of levels of widespread fear of cholera. Contiguously, at a local level, the
blame became more specific which lead to the epidemic being explicitly associated with the poor – whose environments happen to be propitious to cholera outbreaks. This situation is comparable to the 1892 outbreak of cholera in New York City. As the infectious disease was traced to Russian Jewish communities in Eastern Europe, in the U.S., all European Jews were plagued by fear, stigmatization, and discrimination related to the infectious diseases in question (Sherman 2007).

**Understanding Cholera**

Based the findings, shifts in blame appears to affect the way cholera is understood among certain groups in the Haïtian population. From a bird’s eye view, there seems to be an interactive motion between the primary group being blamed for cholera and overall understanding of cholera. As previously discussed, the period of the cholera outbreak was characterized by an atmosphere of confusion and fear that gave impetus to various explanations for the pathology of cholera in Haïti. At first, people did not mainly perceive cholera as a disease. As Grimaud and Legagneur (2011) and Williams and colleagues (2012) pointed out, many communities had other explanations for cholera which did not originate from a scientific framework. With the coordinated public health responses to the cholera outbreak and the identification of the UN as the source of the disease’s introduction in the country, more individuals in the population began to accept cholera as a disease from a biomedical, or broadly scientific, perspective. From there, people also blamed the UN for the epidemic. At this stage, a coalition of organizations promoted and encouraged the use of the scientific framework to facilitate the efficacy of public health interventions in communities.
It is unclear which framework became the most dominant; however, from the participants’ accounts, different frameworks coexist in various communities. As the years passed, the scientific framework progressively took the front stage, and the other frameworks took alternative positions. The prevalence of one framework over another is dynamic and is not the sole product of individuals’ characteristics (class, religion, education etc.). The extent to which groups of people are affected by the socio-economic climate of the country and the collective response to it seem to influence the order in which they give primacy to each framework. In the case of this thesis, pervasive poverty, lack of upward mobility, poor financial quality of life and a lack of wellbeing experienced by a group of people seem to influence the prevalence of one framework over another. In my findings, individuals who encounter either economic challenges or are part of an economically disadvantaged group, tend to describe cholera within frameworks other than the biomedical. In the interviews and during informal conversations with people during my observational outings, many people appeared to soften the menace of the infectious disease and the importance of potable water consumption. That attitude is often translated by the Haïtian proverb mikrob pa touye aysyen and interpreted as a way to either convey that Haitians cannot die from microbes, or that untreated water does not pose a threat to people’s health – like a suspension of disbelief (Grimaud and Legagneur 2011; Williams et al. 2012). In relation to structural forces, I posit that this belief or attitude of invincibility toward cholera is in response to blame. Either it is a way to resign oneself to the ones’ lack of agency, or it is a way for marginalized groups, especially the economically disadvantaged, blamed locally for the perpetuation of the epidemic, to currently cope with addition external pressures.
In Mead’s view (1936), when something is named, it is assigned a meaning. This process is facilitated by the use of language that is used by individuals to negotiate meaning through significant symbols. According to him, the communicational process is a social act within which meaning arises. This process has a triadic structure that includes three mechanisms: an initiating gesture by one entity; a response to that gesture by another entity; and the outcome of that action initiated by the first gesture (1936:76, 81). Throughout the life course of the epidemic, the meaning of cholera has been dynamic, changing with the social and epidemiological evolution of the epidemic. In the current conjuncture, individuals understand cholera as the disease of the poor imported by UN soldiers. Given the process laid out by Mead, and the mechanism of shifting blame connected to Farmer’s ‘cycle of accusation,’ the understanding of cholera in contexts other than the scientific one could be viewed in response to the overall conceptualization of this disease. The perceived threat of cholera is diminished and its risks factors related to poverty. With these specifications, the blame became more focused on individuals exposed to these risks factors. In terms of proportions, the majority of individuals in Haïti lives in extreme poverty and are exposed to astonishing levels of inequality (Smith, Gelineau, Seligson 2012; Farmer 1992). Given these ensnaring circumstances and the current focus of the blame, the use of other frameworks within which cholera is not a medical disease can be considered. There is no meaning independent of the interactive participation of people in the act of communication. When the nature of the infectious disease is examined, its etiology and its mode of transmission, the conditions propitious to its emergence and spread happen to be part of the reality of certain group of people. With the country’s conjuncture playing a role in maintaining these conditions, these
individuals' conceptualization of cholera outside of a biomedical framework could be understood as a response to being blamed for the continuation of the epidemic. Furthermore, due to the fact that cholera became endemic, the duration of that cycle of blame is undetermined – which alternatively implicates the pervasiveness of cholera related stigma and discrimination. Considering these macro level dynamics, one could partially understand why certain people do not conceptualize cholera “as a disease” primarily from a biomedical perspective (MSPP 2012).

Limitations

The current study has several limitations. The majority of individuals in my network of participants never had cholera. Some of them alluded to experiencing stigma related to cholera only to recant their stories when I inquired about whether they suffered from the disease. I attribute the retractions to the fear of being stigmatized that has not disappeared in many communities throughout the capital. In this study, the voice of former cholera patients and their caregivers is limited with only three individuals who had an experience related to cholera. One participant recovered from cholera; one participant cared for a family member who had cholera; one participant was exposed to the topic as part of his curriculum in medical school. I compensated for this anticipated shortage by using questions to probe for information on their observation especially if the participant lives in or near areas that are high risks for cholera outbreaks based on the latest epidemiological reports and residents’ suggestions.

Contrary to my anticipation, many study participants treated me as an outsider and that possibly influenced the candidness of some responses. I became more cognizant of this distance after my eighth interview, and consequently allotted more time to
establishing a rapport with potential recruits and shared anecdotes about the times I lived in Haïti to substantiate my ties to the community.

A few factors decelerated the speed of the research process: the unpredictability of participants’ schedules, the lack of electricity, torrential rains, and a few street protests that occurred during the time of data collection. I relied heavily on field notes and transcribed interviews with very sensitive information or potential identifiers myself. To help stay on schedule I hired two professional transcribers for less sensitive interviews. Although I had control over the location of the majority of the interviews, it might happen that many interviewees would have been more comfortable elsewhere. In an attempt to address this potential issue, I asked participants if they are comfortable and eliminated physical barriers that furniture (i.e. desks) may create. If I felt nervous, I shared my feelings with the participants and approached the interview process as a conversation rather than an inquisition.

I was unable to collect demographic data systematically, especially information pertaining to their place of residence, their education attainment and age. I primarily relied on descriptions and references on their milieu of residence or other aspects of their lives to help me probe for information linking environmental factors to cholera. I was unable to compare results according to sex, age or education. Since most people seemed more open to share their occupation, I mostly relied on that indicator.

Even though I am fluent in Haïtian Creole, there is a possibility that I did not adequately convey certain meaning during the process of redacting the results of my analysis and translating quotes. Nonetheless, I translated words and quotes included in
this document to the best of my abilities as a native speaker with the consult of a public health professional that has been educated in English, French and Creole.

**Future Research**

There is a need for more studies conducted from the perspective of Haïtians to provide additional insights on their experiences amidst the ongoing cholera epidemic. Additionally, sociologists could expand on the structural context in which behavioral and attitudinal changes are formed and investigate the effects of the economy on mechanisms of adaptation. Researchers could also investigate the effect of individuals’ characteristics in mitigating the social, economic, and political consequences of chronic cholera outbreaks.

To find binding solutions to the eradication of cholera, researchers from various disciplines must take different approaches to excavate factors, aside from the poor infrastructure, that interact with the consequences of the cholera epidemic.
REFERENCES


# APPENDIX A

## PARTICIPANTS’ INTRODUCTION

<table>
<thead>
<tr>
<th>Pseudonyms</th>
<th>Introduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>BOB</td>
<td>Bob is a community health work in his late 20’s who recently went abroad to get his Master’s degree after working for different international NGO’s since 2010. He is passionate about health promotion and sanitation. When the cholera outbreak occurred in 2010, he was working at a displacement camp for individuals who lost their homes during the earthquake. The cholera incidence rate skyrocketed quickly at that settlement which made him fear for his life. Although he hopes to stay in Haiti and have a professional career, the high unemployment rate and lack of prospects are discouraging. Accordingly, he is planning to emigrate and start his life elsewhere. He has four siblings and was raised by his older sister to whom he owes his life. He is the only one who went to college. He was born and raised in Port-au-Prince. He currently lives near the Downtown Port-au-Prince area and has strong ties to various communities in the capital. He is very passionate about his work.</td>
</tr>
<tr>
<td>BEN</td>
<td>Ben is in his 40’s and was born in the North of the country. He returned to Haiti after obtaining his PhD abroad. He is married, has two children who were born and currently live in North America with their mother. He visits them several times a year. He prefers living in his country of birth where he currently works as a full time professor in two academic institutions and he is a private consultant. He is the director of research center and the owner of a small business. His position as a private consultant allows him to travel in various parts of Haiti. He is gradually building his house and working on his dream to retire comfortably. Ben works more than he sleeps and sees his hectic lifestyle as a small price to pay to maintain his quality of life. He admitted that he would have been barely surviving on professor’s salary. His additional undertakings help him live “like a human being.”</td>
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<tr>
<td>DAX</td>
<td>Dax lives in Carrefour and has a young child who was a toddler in 2010 at the beginning of the cholera outbreak. He works odd jobs whenever he finds them. At the moment. He is current working under the table as a maintenance staff at an institution. His duties include cleaning, fixing things, and running errands for the institution’s workers.</td>
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<td>Name</td>
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<tr>
<td>DROGO</td>
<td>Drogo is a medical student who was in high school during the cholera outbreak of 2010. He is very dissatisfied with the way the Haitian healthcare is managed.</td>
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<tr>
<td>FILIP</td>
<td>Filip is a religion expert who has conducted investigations throughout Haiti. He considers himself to be part of the lower middle class and shared that he lives in a slum but is well off compared to his neighborhoods. He has a house, a car and enjoys certain privileges that are not available to the majority of the population. He vacations abroad whenever he can. He vehemently believes that the Haitian Ministry of health has enough funding to better address issues related to the epidemic.</td>
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<tr>
<td>GARY</td>
<td>Gary is a professor. During the earthquake of 2010, his apartment was destroyed. Several of his family members emigrated shortly after. He went abroad for a few months and returned around December 2010 and moved in a house with his aging mother. He studied abroad and travels whenever he can.</td>
</tr>
<tr>
<td>JEAN</td>
<td>Jean recently got his Master’s degree in North America and would like to further his education abroad. He is currently an assistant professor. He was raised in Pétionville. He went to private school his entire life and describes his childhood as agreeable.</td>
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<tr>
<td>JOHN</td>
<td>John is from the South of Haiti and works as a professional driver. He describes himself as a fervent catholic. He currently works for a local NGO where he transports individuals who conduct field work throughout Haiti. He is particularly marked by the appalling living conditions of Haitians deported from the Dominican Republic who current reside under tents near the borders.</td>
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<tr>
<td>KATELY</td>
<td>Kately is a first year of college student. She is from the South of Haiti and was sent to Port-au-Prince by her mother as tween to have access to a better education. She currently lives in an apartment with her younger sister. Her mother, her aunt, and godfather help them with expenses since they are unable to find work. She takes her schooling very seriously despite of facing many hardships. One of the toughest obstacles she faces is low access to portable water. Kately and her sister have to buy buckets of water and carry them to their apartment. She remains very optimistic and wishes to get a PhD in religious studies.</td>
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<td>Name</td>
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<tr>
<td>LALA</td>
<td>Lala lives in Carrefour. She describes herself as the soldier of God. She is raising three kids by herself. She works as an ambulant product vendor (washing products, food) and a street vendor (food, second hand clothes). She goes to church often and is part of a religious group that prays for the sick and helps those in need.</td>
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<tr>
<td>LILY</td>
<td>Lily is the only child and has recently graduated from high school. She is a college student who would prefer having a professional career before getting married and having kids. After getting her Master’s degree, she would like to travel to France or Canada to get a PhD. She believes that the earthquake has exacerbated living conditions in Port-au-Prince and intensified poverty. Both factors are stripping people of their humanity.</td>
</tr>
<tr>
<td>LOU</td>
<td>Lou is a professor at a university. He used to live abroad before returning to Haiti to hold his current position. He currently lives in a select gated community with his wife who is a professional. Although the cost of living is expensive, he perceives it as a small price to pay to have a good quality of life.</td>
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<tr>
<td>NADIA</td>
<td>Nadia did not say much about herself. She informed me that it was a tradeoff for her honestly: near anonymity for honesty. She is in her 20’s. She lost a lot during the earthquake and has been prostituting herself to survive. She wished that she could go to school like me and worry about studying, papers instead of her next meal.</td>
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<tr>
<td>MAGDALA</td>
<td>Magdala is in her late 30’s. She is the youngest of five siblings. She is single, never married, and has no children. Three of her siblings live abroad and help her with medical expenses to manage a chronic illness. She currently lives with one sister and is helping her raise her kids. They are all from the North of Haiti. Magdala attended college for one year after graduating high school. She has not had a full time job her entire life and has been impacted by the country’s job insecurity. She lived in a displacement camp after the earthquake for approximately one year.</td>
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<tr>
<td>MANOU</td>
<td>Manou works as part time as a social worker. He works mostly with orphans – especially children who lost their parents after the earthquake. He is currently getting his Master’s degree in psychology – he wishes to become a child psychologist. Manou volunteered after overhearing my recruitment pitch when he was having lunch at a local park where I was trying to recruit potential participants.</td>
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<tr>
<td>MANOUCHKA</td>
<td>Manouchka is from the South of Haiti. She moved to Haiti’s capital with her best friend in the pursuit of a better life as a vegetable merchant. After being robbed one day, she decided to work as a full time maid. She is hoping to save enough money to go back to selling fresh vegetables. She found this latter job more dignifying and profitable. She despises working as a maid as employers can be bellicose, verbally abusive, and have “slave owner like attitude.” For now, it is what it is.</td>
</tr>
<tr>
<td>MARJ</td>
<td>Marj works as an administrator in a university. She is also a business owner in the public transportation sector. She has a Master’s degree in Sociology. She lives in Carrefour and has a strong aversion to dust, detritus, and the “nauseating” corruption in Haitian government. Despite of the difficult way of life in Haiti, Marj remains hopeful that things will be better and has no desire to emigrate like many of her friends. Many of her family members emigrated. She is contemplating sending her kids abroad to further their education.</td>
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<tr>
<td>MARTHA</td>
<td>Martha is from the South of Haiti and is an accountant at an institution. She lives in Carrefour and knows a lot about Port-au-Prince from taking public transportation.</td>
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<tr>
<td>MARY</td>
<td>Lala is from the South of Haiti and has two older brothers. When they were children, her parents only sent her brothers to school and taught her the ropes of farming and housekeeping. After her husband’s death ten years ago, her brothers monopolized the land they inherited from their parents, leaving Lala with nothing. Soon after, she lost her business of selling fresh produce in bulk at the capital. She moved to Port-au-Prince with her four kids and started working as a full time maid to support them. She kept working as a maid despite the poor conditions. In the past year, she got fired often, especially at the peak of the cholera epidemic, for “looking like someone with cholera.” Being unable to eat properly, she shared that she lost a lot of weight over the years, but she is not sick. Although she lives in a close knit community where neighbors support each other, she is often excluded and gossiped on because she does not have a husband.</td>
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<tr>
<td><strong>MOONIE</strong></td>
<td>Moonie recently graduated high school and is currently preparing to take entrance exams in different colleges. She is an only child and considers herself a mummy’s girl. She is currently involved in a youth group where he is learning a lot about community work.</td>
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<td><strong>PETE</strong></td>
<td>Pete is a case manager at a community based organization. He deals with a lot of cases of orphans who lost both parents to cholera. He was born in a rural area of the West of Haiti where his father, a farmer, sold pieces of his land to send him to school to Port-au-Prince. He visits his family whenever he can. Although he prefers the country side life, the unemployment rate and the living conditions are too harsh. His favorite childhood memory is swimming in river near his father’s mango plantation.</td>
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<tr>
<td><strong>PONYO</strong></td>
<td>Ponyo studied accounting a long time ago. He has not been able to hold a stable job as an accountant since the fall of the political party under which he found work in 2004. He resorted to working under the table or applying to temporary positions that do not always pay on time. He still has not received the last paycheck from a temporary position he held three months ago. He moved his wife to his place of birth at the North of the country where he inherited his parents’ house. He resides in Port-au-Prince for work. In tougher times, he lives from the generosity of his friends. They all help each other (with food, services, money etc.) when they experience hardships. In the end, it is easier for him to find an alternative in the capital than elsewhere.</td>
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<tr>
<td><strong>RICK</strong></td>
<td>Rick had a very conservative religious upbringing; he describes himself as an agnostic. He loves his father dearly but gets in thunderous arguments with him on religious matters. He is from the North of Haiti. He has been living in Port-au-Prince for a while and is working on his Master’s degree.</td>
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<tr>
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<td>DESCRIPTION</td>
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<tr>
<td>ROMAIN</td>
<td>Romain is a young man who had cholera five years ago. If it were not for his sister, he would have died on the street of his neighborhood where he collapsed. He did not get out of his house for an entire year after coming out of the hospital. Meanwhile, he received death threats from neighbors who were afraid of getting sick. His family members were denied services because of him. Five years later, he still feels “strange” as if something in him is missing. Aside from his family members, no one would talk to him, let alone touch him for a while. Nowadays, although people are more accepting of him, he gets mercilessly taunted on the streets by those who knew of his former condition. They call him names like <em>kakatoue</em> or cholera. He shared that his feelings get hurt a lot, but his sister’s love gives him strength. His worst fear is to get cholera again. He desires to help cholera survivors anyway he can, but he does not know how. When he was in middle school, he had difficulty learning, so he dropped out.</td>
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<tr>
<td>SANTIA</td>
<td>Santia is a stay at home mother. She lives with her husband, a construction worker, and their four kids. She used to work as a maid; however, the deploring working conditions and the low pay made her decide to stay at home and raise her kids. She lives in a close knit community where neighbors support each other. They share food, lend each other money etc. She would like to be a business owner (convenient store, or street vendor), but the high cost of living makes it near impossible for her to set money aside. Santia cared for her sister who had cholera.</td>
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<tr>
<td>SMITH</td>
<td>Smith runs a restaurant with his wife and is very pleased with his clientele. His mother was a businesswoman who bought merchandises in bulk overseas and sold them in Haiti. Being the only child, he inherited her business and all her properties in the country side which he converted into vacation houses for foreigners to rent. He was sent abroad as a kid to get a better education and returned to the country as a young adult.</td>
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<tr>
<td>SOFIA</td>
<td>Sofia is a single mother of two children in her early 40’s. One child is in college and the youngest is in fifth grade. She is originally from the North of Haiti and moved to Port-au-Prince in the pursuit of a better life. Sofia has not had a full time job since 2006. She has been moving from one-part time low paying</td>
</tr>
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39 A derogatory term to people who defecate often on themselves without control
job to another. Her siblings living abroad have been helping her stay afloat.

**TAMARAKA**  
Tamaraka is a twenty-two-year-old student completing her first year in nursing school. She prefers psychology and would have wanted to be a psychologist. Due to the growing demand for medical professionals in Haiti (especially nurses), and the tough conditions in which her and her family are living in, going to nursing school seems more promising than having a degree in psychology.

**VARICE**  
Varice described himself as a professional. He lost his wife during the earthquake and seems very protective of his only child who currently goes to university. He suffers from a health condition that requires him to be selective with what he eats and punctual in his eating habits. One of his worst fear is to have cholera.

**ZOLA**  
Zola is an eighteen-year-old young man who is in high school (the Haitian educational system is different). He thinks he was born in Port-au-Prince, but he is certain that he is the only child of his parents. His mom is a stay at home mom and runs a local convenient store from their house while his dad a furniture builder. He does not know what he wants to do in life yet. For now, he is more preoccupied with meeting his parents’ demand of excelling at school and hoping that his neighbor’s beautiful daughter will notice him already.
APPENDIX B

ENGLISH INTERVIEW GUIDE

Opening Questions
1. Could you please tell about how you first became aware of cholera?
   a. How/when did you hear about it?

2. Prior to being officially declared an epidemic by the Ministry of Public Health, how aware was your community (katye) of cholera?
   a. Was it informed by the words on the street? Radio? TV?

3. How would you describe the experience of people who have cholera?
   a. How do people react to it?
   b.

4. What are some challenges that came with living in the midst of an epidemic?
   a. How do you and others around you make sense of them?
   b. How would you describe dealing with them?

Intermediate Questions
1. Could you please tell me how a typical day for you looked like before the epidemic?
   a. How would you describe your life then?
   b. Did you cook your own food or eat out? / did your maid cook your meals? (If applicable) /Where did you typically eat?
   c. How would you greet people (kiss on the cheeks, or handshake)?
   d. How often would you use water? (Shower, dishes etc.)

2. What about people in your social circle, how did they interact with each other?
   a. Ask about occasion, setting, or place s/he has the most interaction with other people.
3. Could you tell me more about the public services provided in your neighborhood before the epidemic?
   a. How was the access to resources (water, trash pickup, and electricity)?
   b. Would you mind giving me an idea on how these resources were managed in your household and your neighborhood?

4. Would you mind telling me what a typical day looks like for you now?
   a. How would you describe the different aspects of your life discussed earlier now?
   b. How do you deal with having cholera (if appropriate)?
   c. Tell me about your thoughts and feelings regarding the disease and the way it is perceived in Haiti.
   d. Has the way you view or interact with people change because of this epidemic? What about people around you?
   e. How has the spread of the infectious disease influenced these various aspects of your life?
   f. Did you have to make certain adjustments (i.e. washing hands often)? If so, could you describe the moment (or event) that led up to you feeling like you had to make certain adjustments to your daily life to adapt to the epidemic and protect your health?

5. The government has released many PSA (Public Service Announcements) on how to protect yourself from having cholera. Could you tell me how you organize yourself around these adjustments? Have you reached a point where you feel like things can started to feel stable to you?
   a. Are you able to follow the health guidelines word for word? (I.e. buy bottles water).
   b. What are the most helpful things (friends, neighborhood, vehicle etc.) that can make it easier for someone to adapt to the changes in the midst the epidemic?

6. How has your overall experience been throughout the cholera outbreak?
   a. Is it a solitary experience or do you get support from family and friends?
   b. How affected are you or people around you by the epidemic?
   c. Do people help each other out? If so, how?
Ending Questions
1. Is there a different way the current situation could have been handled by officials?

2. If you had the opportunity what would you say to government officials, what would you say is the most important issue that needs to be tackled at the moment?

3. Is there something else that I should know to have a better understanding of your experience?

4. Is there anything you would like to ask me?

Demographic Info
1. Age? Place of birth in Haiti?

2. In which commune do you reside?

3. What is your occupation? Education?

4. Number of children, marital status?
APPENDIX C

VERBAL CONSENT SCRIPT

I am asking you to take part in a research study because I am trying to understand the extent to which the cholera epidemic has changed your daily life in the country. For that purpose, I will ask you questions about your thoughts on the cholera epidemic, the way your daily life was before and after the epidemic, and how you are managing to protect your health. I might ask you about your experience with other epidemics or outbreaks, such as tuberculosis, that have occurred in the country and compare them to the current cholera epidemic. I may ask you if there are people you know who could be interested in participating in the study. I am not evaluating your expertise, rather I want to know your opinion and your experience of living in a country with a cholera epidemic.

The length of time for the interview is estimated to be between 30 to 45 minutes. It will be audio-recorded [SHOW RECORDER AND MICROPHONE WHEN PERSON IS PRESENT]. It is done that way to make sure that what we talk about during this interview is what I use in the study. You also have the option to have a phone interview if in person interviews are not convenient for you. You might get a short follow-up call in case I have more questions or if the epidemic takes another wingspan in the country. I will be the only one to have access to the audio recording of the interview. It will be erased as soon as it is transcribed. Only I and my supervisor, Dr. Linda Belgrave, will have access to the transcription of the interview. All documents related to the study will be stored in a password protected online storage system maintained by the University of Miami. I do not foresee any risks to your participation in this interview beyond being saddened or upset in discussing your experience during the epidemic. You are free to skip questions that you don’t want to answer, or withdraw from the interview at any time without giving any reasons. If you do not wish to be recorded, this will mark the end of the session. Your contact information will be saved on an encrypted filed on my password protected computer.

There are no personal benefits from participating in this study, though it will help us understand peoples' experiences with epidemics. At the end of the interview, I will offer you a token of my gratitude. We can talk about that now or later

(**IF NOW, PROCEED AS FOLLOWS**)

Inform the participant of a “small” token of my gratitude, disclose the amount (equivalent of $10 USD), and then give them the time to accept it or not.

(**IF ACCEPT, PROCEED AS FOLLOWS**)

Ask whether they would like be gift to be wired to their phone or given in cash. The cash will be in a white envelope. Give them the space to decide.
Your real name will not be used on any report related to the study; a fake name will be used to refer to you during the interview. That fake name will also be used in any direct quotes from your interview on documents related to the study as well. No participant will be identified in any way.

Your participation in this study is voluntary. You are free to refuse to participate in the study or withdraw your consent at any time during the study without any negative consequences to you.

Do you have the time to participate in this research study? Would you like to participate now or at a later time? In person or on the phone?

Answering the upcoming interview questions means that you consent to participate in this study. Do you have any questions before we start?

If you have any other questions concerning the research study, please call me at 001-786-486-4886 or email me at k.seide1@miami.edu. You could also contact my research supervisor, Dr. Linda Belgrave at 001-305-284-6762 (office) or l.belgrave@miami.edu (email).

If you have any questions about you rights as a research participant, contact the University of Miami Human Subject Research Office at 001-305-243-3195.

Do you give consent to participate in today's interview?
APPENDIX D

INTERVIEW GUIDE IN CREOLE

Kèk kesyon pou kòmanse
5. Ëske w kapab di ki jan ou te fèk vin o kouran afè kolera a?
   b. Ki jan/ki lè ou te kòmanse tande pale de sa?

6. Avan Ministè Sante Piblik te deklare ofisyèlman gen yon epidemi, ki jan moun ki rete nan katye kote w rete a te vin o kouran afè kolera a?
   b. Ëske se nan lari moun te tande pawòl la? Nan radyo? Nan televizyon?

7. Kòman ou ta esplike jan moun ki gen kolera viv ak maladi a?
   c. Ki jan moun reyaji parapò ak maladi a?

8. Ki difikilte moun te genyen pandan epidemi a?
   c. Ki jan ou memn ak nan zòn ou yo te wè difikilte sa yo?
   d. Kòman ou ka dekri jan ou te fè fas ak difikilte sa yo?

Kèk kesyon pou kontinye
7. Di m kòman ou te konn pase jounen w avan epidemi an?
   a. Kòman ou kapab dekri jan lavi ou te ye lè sa a?
   b. Ëske ou te konn fè manje w oubyen ou te konn manje deyò /Ëske se bòn ou ki te konn fè manje pou ou? (si w te gen bòn lakay ou) /Ki kote ou te konn manje an jeneral?
   e. Ki jan ou te konn salye moun (yon ti bo bò figi, oubyen bay lanmen)?
   f. Konbyen fwa ou konn sèvi ak dlo? (Beyen, lave veso, eksetera)

8. E moun ki nan sèk sosyal ou, ki jan yo te konn kominike youn ak lôt?
   a. Poze kesyon konsènan ki okazyon, ki kote li plis an kontak avèk lôt moun.

9. Ëske w te kapab ban m plis enfômasyon sou sèvis piblik yo te konn bay nan katye ou a avan epidemi a?
a. Kòman moun te kapab jwenn resous (dlo, ranmase fatra, ak elektrisite)?

b. Èske sa pap deranje w pou w ban m yon ide sou jan nou jere resous sa yo nan fwayne w e nan katye w?

10. Èske sa pap deranje w pou w di m ki jan ou pase yon jounen nòmal kounye a?

g. Pou diferan aspè lavi ou nou sot diskite talè a, kòman ou kapab dekri yo pou jounen jodi a?

h. Kounye a ou gen kolera kòman ou fè fas avèk sitiyasyon sa (si patisipan an gen kolera)?

i. Pale m de sa w panse ak sa ou santi konsèn maladi ak jan moun wè li ann Ayiti.

j. Èske fason ou wè moun oubyen fason ou kominike ak moun chanje akòz epidemi sa? E moun nan antouraj ou?

k. Ki jan maladi moun trape nan men lòt moun enfliyanse divès aspè nan lavi ou?

l. Èske w te oblije fè sèten ajisteman (pa egzanp, lave men w souvan)? Si w te oblije fè sèten ajisteman, èske w kapab dekri okazyon (ou evènman) ki te fè w santi kòmkwa ou ta dwe fè sèten ajisteman nan jan ou mennen vi w toulejou pou w adapte ak epidemi an e pou w pwoteje sante ou?

11. Gouvènman an te pibliye anpil Anons Sèvis Piblik sou fason ou kapab pwoteje têt ou pou w pa gen kolera. Èske ou kapab di m ki jan ou òganize têt ou ak ajisteman sa yo? Èske w rive nan yon pwen kote ou santi kòm si bagay yo ka kòmanse parèt estab pou wou?

c. Èske w anmezi pou w swiv rekòmandasyon an matyè sante yo mo pou mo? (paegzanp, achte dlo nan boutéy).

d. Ki sa ki kab pi itil yon moun (zanmi, vwazinaj, machin, eksetera) pou l sa adapte l pi fasil ak chanjman epidemi lakòz?

12. Kòman sa te pase pou wou pandan epidemi kolera a?

d. Èske se yon esperyans ou fè pou kont ou oubyen èske fanmi w ak zanmi w te ede w?

e. Ki efè epidemi sa a fè sou wou epi sou moun k ap viv pre ou?

f. Èske youn te ede lòt? Si yo fè sa, kòman?
Kèk kesyon pou fini

5. Èske dirijan yo te ka jere sitiyasyon a yon lôt jan?

6. Si ou te gen chans pale ak dirijan gouvènman yo, ki sa ou ta di yo? Ki koze ou panse ki pi enpòtan dirijan yo ta dwe abòde kounye a?

7. Èske gen yon lôt bagay mwen ta dwe konnen pou mwen ta pi byen konprann esperyans ou fè a?

8. Èske gen yon bagay ou ta renmen mandle m?

Enfòmasyon demografik

5. Laj ou? Kote w fèt ann Ayiti?

6. Nan ki komin ou abite?

7. Ki metye ou? Ki klas ou fè?

8. Konbyen timoun ou genyen, eta sivil ou?
APPENDIX E

VERBAL CONSENT SCRIPT IN CREOLE

M ap mande w pran pa nan yon etid paske m ap chache konprann nan ki degree epidemi kolera a chanje jan w ap viv chak jou nan peyi a. Se poutèt sa mwen pral poze w kèk kesyon sou sa w panse de epidemi kolera a, jan w te konn ap viv chak jou anvan epidemi ak jan w ap viv chak jou apre epidemi a, epi ki jan ou òganize w pou w pwoteje sante w. Mwen ka poze w epidemi sou esperyans ou fè avèk lòt epidemi tankou tibèkiloz ki te pase nan peyi a epi konpare yo ak epidemi kolera kounye a. Mwen ka mande w si gen moun ou konnen ki te ka enterese patisipe nan etid la. Se pa konesans ou m ap evalye, men se konnen mwen ta renmen konnen opinyon ou ak esperyans ou kòm yon moun k ap vin nan yon peyi ki gen yon epidemi kolera.

Valè tan mwen kalkile entèvyou a ka dire se ant 30 a 45 minit. M ap anrejistre entèvyou a sou kasèt [LÈ MOUN NAN RIVE MONTRE L APARÈY ANREJISTREMAN AN AK MIKWO A]. Sa fèt kon sa pou m ka sèten sa nou pale pandan entèvyou a se sa mwen itilize nan etid la. Ou gen dwa chwazi fè entèvyou a pa telefòn si sa pa posib pou fè entèvyou a fas a fas. Sizoka mwen ta gen plis kesyon, mwen k ab telefone w pou m fè yon ti pale avè w tout kou, oubyen si epidemi an ta pran yon lòt dimansyon nan peyi a. Se mwen sèl k ap kapab koute anrejistreman entèvyou a. M ap efase l kou m fin ekri l sou papye. Se sèl mwen ak sipèvizè mwen, Doktè Linda Belgrave, k ap kapab li transkripsyon entèvyou a. N ap sere tou dokiman ki gen rapò ak etid la nan yon sistèm pou konsève dokiman sou entènèt ki pwoteje ak yon modpas; se Inivèsite Miyami ki ap jere sistèm sa a. Si w pran pa nan entèvyou sa a, sa pap poze oken danje pou wou, sèl bagay ou kab santi w tris owsa ou kab santi w yon yan kontrarye pandan w ap pale de esperyans ou pandan epidemi an. Ou lib pou w sote kesyon ou pa vle reponn. Epi tou ou lib pou w sispanna pran pa nan entèvyou a nenpòt lè san w pa oblige bay okenn rezon. Si w pa vle m anrejistre vwa w, n ap tou fini ak sesyon an. M ap sere kowòdone ou nan yon fichye kode nan òdinatè mwen ki gen yon modpas pou pwoteje òdinatè a.

Pa gen okenn avantaj pèsonèl poutèt w ap patisipe nan etid sa a, men etid la ap ede nou konprann esperyans moun ki pase nan anba epidemi. Nan fen entèvyou a, m ap ba w yon ti kado pou remèsye w. Nou ka pale de sa kounye a oubyen pi ta.

(****SI SE KOUNYE A, KONTINYE KON SA***)

Pale patisipan an de “ti” kado remèsiman an, di l konbyen kòb li ye (ekivalan 10 dola ameriken), apre sa ba l tan pou li asepte oubyen pou li pa asepte.

(****SI LI ASEPTE, KONTINYE KON SA***

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Vrènon w p ap parèt nan okenn rapò sou etid la; m ap sèvi ak yon fo non lè m ap pale de ou pandan entèvyou a. Se ak fo non sa a tou m pral sèvi nan tout sitasyon dirèk m ap pran nan entèvyou w la pou m mete nan dokiman ki gen rapò ak etid la tou. Mwen pap idantifye okenn patisipan sou okenn fòm.

Se si w vle w ap patisipe nan etid la. Ou lib pou w refīze patisipe nan etid la epi ou lib pou w anile konstantman ou nenpòt lè pandan etid la san sa pa gen okenn efè negatif sou ou.

Èske w gen tan pou w patisipe nan etid sa a? Èske w ta renmen patisipe kounye a oubyen yon lòt lè? Fas a fas oubyen pa telefon?

Depi ou reponn kesyon mwen pral poze w nan entèvyou a, sa vle di ou dakò patisipe nan etid sa a. Èske w gen kesyon anvan nou kòmanse?

Si w gen nenpòt lòt kesyon konsènan etid la, tanpri rele mwen nan nimewo telefon 001-786-486-4886 oubyen ekri mwen sou imel mwen (k.seidel@miami.edu). Epi tou ou gen dwa kontakte sipèvizè rechèch mwen Doktè Linda Belgrave nan nimewo telefon 001-305-284-6762 (biwo) oubyen ekri sou imel li (l.belgrave@miami.edu).

Si w gen nenpòt kesyon konsènan dwa ou genyen kòm yon moun k ap pran pa nan yon rechèch, kontakte biwo Inivèsite Miyami an ki okipe afè moun k ap pran pa nan rechèch (ann angle, University of Miami Human Subject Research Office) nan nimewo telefon 001-305-243-3195.

Èske w dakò pran pa nan entèvyou sa a jodi a?
APPENDIX F

WATER PRICES

I took the picture of the water bottle on the left; the other pictures do not belong to me. I retrieved them from Google Image in order to provide more context to readers who are not familiar with the types of water sources discussed in the result section. The prices of product listed below were recorded by the researcher from the participants’ accounts. The currency was converted at the currency exchange of that day: $ 1 USD = 60 HTGDES.

1.5 L Water Bottle
50 HGDES = 0.83 US Cents

5 Gallon Water Bottle
85 HGDES = 1.42 USD

Sachet Water
3 for 5 HGDES = 0.083 US Cents

Water Delivery by Truck
10,000 GDES = 166.7 USD

Water Bucket
25 GDES = 0.42 US Cents