Report of Findings:

Health Needs Assessment of Women in Cap Haitien

konbit Sante
CAP-HAITIEN HEALTH PARTNERSHIP

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Funding provided by the Conservation, Food, and Health Foundation; Boston, MA

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I. Introduction and Background

Purpose
Konbit Sante, with funding from Conservation, Food and Health Foundation, undertook the challenge of doing a comprehensive needs assessment of women's health needs in Cap Haitien. The purpose of this study was to attain understanding of how women contextualize their health in order to inform women's health programming in Cap Haitien, Haiti. More specifically, the study identifies the priorities women place on health, how they define health, and how they understand and prioritize their health problems. The women's responses are compared to the responses of health care providers to indicate discontinuities in the way that women and providers perceive women's healthcare and healthcare needs. Relevant literature and research data is also reviewed. The thesis argues that a concerted effort to improve women's empowerment is the most effective way to improve these misapprehensions and to raise women's health status through broad improvements to service provision.

1.1 Background

Haiti is the poorest nation in the Western Hemisphere and one of the poorest 25 nations in the world. Haiti's history has been marked with cycles of oppression and political instability almost since it fought and won it's independence from France in the 1804 – making it the first free black nation [1]. An armed rebellion removed the last president, Jean-Betrand Aristide, in February 2004 and under the United Nations (UN), an interim government took over to organize new elections – which were not completed until February 7, 2006 due to continued violence and technical delays [2].

The life expectancy for Haitian women is about 54 years. According to Demographic and Health Surveys (completed and published in 2000), almost a third of all women have no education, and 40% of women have unmet family planning needs [3]. Literacy rates hover around 65% for both men and women. Fortunately, there seems to be increased enrollment in primary school; currently 95% of children are enrolled, but only 43% of women have completed primary school [4]. Child mortality is 118/1000 live births and maternal mortality is 680/100,000 live births [5]. The maternal mortality estimates, although variable – ranging between 470 [6] and 960 [1] – consistently indicate the highest maternal mortality in the Western Hemisphere and rank among countries in sub-Saharan Africa.

1.1.1 Cap Haitien Public Health Facilities

Cap Haitien is the second largest city in Haiti and is located in the Northern Department (Appendix A). The Justinian Hospital (JUH) is the largest governmental hospital north of Port-au-Prince and is the primary tertiary care resource for the Cap Haitien population of over 200,000 people, and much of the whole Northern Department, a community of approximately 800,000 people. This 300-bed acute care hospital provides surgical, medical, pediatric, obstetric, family medical and additional other care.

The health and medical care system in Cap Haitien has been chronically under-funded. There are inadequate numbers of health care professionals in the Cap Haitien community at every level, from physician to *agents sante* (community health workers). Inadequate stocks of various critical medicines are common. When there are supplies, patients must pay in advance for them. The hospital's physical structure has been partially destroyed by fire and is currently being rebuilt, and large parts of

the campus are inadequately maintained. There is no potable water at the hospital and systems that dispose of biological waste and wastewater are inadequate. The hospital's wiring is antiquated; the power supply is unreliable and periodic power surges have destroyed many pieces of equipment including three x-ray machines, an EKG machine and several surge suppressors. The hospital has two operating rooms that are fully functional and will hopefully be opening an operating room in the maternity ward specifically for obstetric emergencies. The hospital does not have its own blood bank. There are no isolation services so patients with active tuberculosis share the wards with sick patients who have not yet contracted the disease.

Further, existing systems of care for women's health problems are characterized by fragmentation and lack of communication that exacerbate poor health outcomes. For example, prenatal care may occur in a clinic without communication to the hospital where the delivery of the infant will occur. Lay midwives are often poorly educated and have no method for communication or transfer of patients in need. Maternal education and family planning programs are fragmented and not coordinated. There is no identified leadership at the Justinian Hospital for developing a community-wide educational program for women's health [7].

1.1.2 Konbit Sante

In 2004, Konbit Sante applied for and was awarded a grant from Conservation, Food, and Health Foundation based in Boston, Massachusetts to conduct this women's health needs assessment for the purposes of future women's health programming.

Konbit Sante is a 501(c) 3 non-profit organization established in January 2001 with a mission: "To support the development of a sustainable health care system to meet the needs of the Cap-Haitien community with maximum local direction and support." The goal, simply put, is to improve the capacity of the Haitians themselves to deliver quality health care, thereby making positive changes sustainable.

The initiative began in 2000, when a small group of medical and non-medical professionals, many of whom had had international experience, including a number of former Peace Corps Volunteers, began to talk about developing a long-term sustainable health project in an underserved area outside the United States. In November 2001 Konbit Sante chose Cap-Haitien, Haiti and the Hôpital Universitaire Justinian (JUH) as Konbit Sante's partner site.

1.1.3 Women in Haiti

Women are more poor than men. The increase in numbers of poor women in the poorest 41 developing nations was 17% higher than the increase in numbers of poor men over the last 20-year period. It is estimated that 70% of the 1.2 billion people living in poverty are females. Women are also more likely to be malnourished [8]. Women in Haiti follow this trend, as they are less educated than men, earn less than men, and suffer more often from malnourishment [3].

Women have been called the 'magic potion' of development [9]. They are viewed as such because when women are given more economic power they 1) work towards equality and control over their own lives (generally decreasing fertility, violence in the home, etc), 2) contribute directly to their children's human capital through nutrition, health and education, thereby contributing to 3) the wealth, well-being, and income growth of their nations [9].

Women can make significant contributions to public health. "[Investing in women's empowerment] has proved to be one of the best means of achieving sustainable development, which in turn has a clear positive impact on the health of women and their families [10]." They are significantly better at repaying and making profits in microfinance schemes and are proven to invest more in their communities and families than men. However, WHO warns that the empowerment of women through programming is limited to – at least at the beginning – the infrastructure already in place and the voice women already have in their communities. There must be local want and support of women's empowerment.

In Haiti, women are the primary caregivers in the home and often the primary economic providers. Often they are the only caregiver at home as men either travel for work, are not present (deceased or have abandoned their families), or have multiple families which they might or might not support [11]. Therefore, it is in targeting the women that we achieve household wellness. Women in Haiti are also often burdened with a lack of choices about sex, pregnancy, and childrearing. Women are often unable to protect themselves during sexual intercourse because of the demands of their husbands or boyfriends. The birth rate is 4.8 children per woman. Only 20% of women from ages 15 to 49 use a modern contraceptive method. Although frequently exposed to STDs, women often lack the resources to deal with their infections [3].

1.1.4 Human Security

Human security is a framework in which to organize the humanitarian needs of a country – specifically those required to maintain stability. The provision of human security establishes a "floor" on which development can occur. Human security theory stipulates that a core bundle of basic resources (material, psychological, social) are needed to ensure a minimum level of survival. The presence of human security assumes that basic life support elements have been delivered – food, water, shelter, and security from grave violence. Human security includes concepts of distribution, psychosocial wellbeing, and time. The basic components of human security can thus be divided into:

1. Immediate needs
2. Community needs
3. Future needs [12]

Immediate needs include a sustainable sense of home which stipulates that necessities can be ensured and that women are not needing to scrounge for their basic needs on a daily basis. These immediate needs include sustainable access to food, water, shelter, etc. ***Community needs*** include constructive social and family networks and a positive sense of community. These needs generally include schooling, necessary income-generation, access to community spaces and public services, and attention to gender issues. The last component, ***future needs***, focuses on the community having a positive grasp of the future, a prerequisite for investment and future program development. Future needs include higher education, attitudes of the community regarding their state, and macro-economic opportunities as well as international components. This framework will be used to organize the priorities identified by the women participants in this study, and for the comparisons of the provider and women responses.

1.2 Discussion of Methods

Qualitative research methods were used to give women the opportunity to bring up priorities as they thought of them. Questions were open ended to allow for discussion and probing techniques were used to investigate topics brought up by the women. Focus groups were used in the interest of time

– as only one month was spent on data collection. Key informant interviews were conducted with community women and providers of care to women, both in the community and at the hospital.

1.3 Discussion of Presentation of Results

The results are organized as closely as possible to the way the women responded, which generally followed the model of human security explained above. They are further categorized into Basic Needs, Public Services, Social and Economic Issues, Health Issues and Internationalization. While the providers were more apt to categorize the women's needs into causes of ill-health, cultural and social issues affecting health, and direct perceptions of health, in order to maintain the integrity of the women's responses, the report is organized by the women's priorities.

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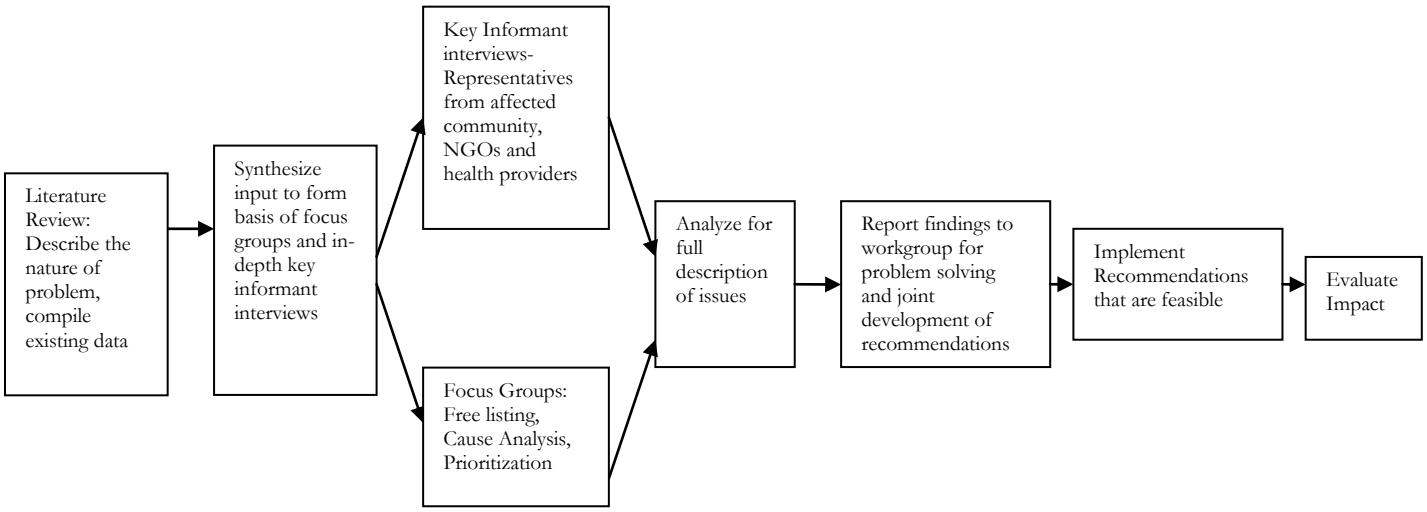
II. Methodology

The women's health needs assessment was based on and organized according to the schematic

Figure 1: Flow chart of Women's Health Needs Assessment and Recommendation



Goal: to understand breadth of problems: the "whats"	Goal: to understand depth of problems: more nuanced, the whys"	Goal: develop a plan of action	Goal: Improved health outcomes

below:

Figure 1. Schematic of women's health needs assessment in Cap Haitien, created by N.Nickerson, 2006 [2].

The literature review was conducted from months September to December, 2005, by MaryAnn Dakkak and Nate Nickerson. Then, the focus groups and key informant interviews were written by MaryAnn Dakkak, and approved by Harvard School of Public Health Internal Review Board. Joia Mukherjee, Nancy Dorsinville, Nate Nickerson and Paul Bolton assisted in formulating the focus group and key informant questions.

2.1 Focus Group Methodology

2.1.1 Selection of Geographic Area for Focus Groups

We selected women from different neighborhoods according to contacts made by the team members in Cap Haitien as well as identified women who were both accessing and not accessing the healthcare system. Existing communities were chosen for most focus groups.

2.1.2 Selection of Focus Group Staff

One Konbit Sante staff member (French fluent) trained a team of six Haitien medical residents and nurses to conduct and take notes for focus groups. Two team members worked as moderators/translators for the focus groups, and four team members worked as

observers/recorders. These women were trained for their respective positions, and all were bilingual in French and Creole. These six women were trained the first week of January (3-6). The Haitian staff was trained in focus group facilitation using the methodology of Richard A. Kruegar [1]. Groups were chosen in order to achieve as diverse a geographical and socioeconomic representation as possible.

Over a three-week period, 19 focus groups were conducted in different areas of Cap Haitien.

1. Women selling at the market: one group
2. Sacred Heart Center (a nutrition program) clients: four groups
3. Fort St. Michel Clinic catchment area patients and staff: four groups with women, one with nurses
4. Ouevre des Jeunes (literacy program): one group
5. Cite Chauvel Baptist Church: four groups
6. Justinien Hospital: one group of nurses, one group of traditional birth attendants
7. Petite Anse (a geographical area) women's group: two groups

2.1.3 Selection of Focus Group Participants

Meetings were held with leadership identified by team members in the communities to choose the women involved in the focus groups. Each community leader was given a week to give notice to and separate the women into age groups (15-24, 25-34, 35-54, 55+). Each community liaison informed those choosing participants that we were looking for a representative sample of the women they encountered in their work – and a sample in which there was equality among women (i.e.: there is no 'head' female present that will control the conversation).

2.1.4 Focus Group Questions

Each participant was consented into the focus group. Team members read each participant (one-on-one) the consent form and procedures and asked the participant for their signature (or a mark). Each participant was asked a few demographic questions individually prior to the focus group questionnaire. The initial question guide was written in English and French by Konbit Sante staff and translated into Creole by the hired Haitian team. The questions were reviewed by the Harvard University IRB as well as the MSPP and medical staff in Cap Haitien. All forms and questionnaires can be found in the appendices.

2.1.5 Logistics

The focus groups were completed in neighborhood centers of the women participating. Lunch was provided at each focus group and paid for by Konbit Sante. There was no other payment given for participation. Focus group content and comments were recorded by a digital recorder, and notes on each session were taken by at least two team members. A large whiteboard was used to record the free-listing and problem tree drawings, and were later transcribed. Each focus group lasted between 1-2 hours.

2.2 Key Informant Methodology

2.2.1 Selection of Key Informants

The key informants were identified by questioning the women involved in the focus groups as well as the leadership in the area of which persons would serve as good key informants. Providers were chosen from diverse fields, including: family practice, obstetrics, cardiology, psychology, nurses, community health workers, nutritionists and women's rights activists.

2.2.2 Key Informant Interview Questions

The initial question guide was written in English and French by Konbit Sante staff and translated into Creole by the hired Haitian moderator/translators. The questions were reviewed by the Harvard University IRB as well as the MSPP and medical staff in Cap Haitien. These guides were further lengthened by information provided in the focus groups as well as information gathered from the literature that needed clarification.

2.2.3 Logistics

Key informants were either interviewed in their workplace or at the hotel where Konbit Sante staff lived for the duration of the interviews. Each interview lasted between 1-3 hours. Interviews were often conducted over meals. All interviews were both recorded with a digital recorder, and written notes of each interview were taken by one of the Haitian staff working as a note-taker.

2.3 Limitations to the Study

The study sample is not a random sample of Cap Haitien women or Haitien women. Because of tight resources in both time and finances, Konbit Sante worked through local contacts to find groups of women, or to create groups of women to interview. Broad generalizations regarding Haitien women should not be made based solely on the results of this study. The study does not go into specific detail on many beliefs on specific diseases or conditions; therefore the information on specific diseases or conditions in this report are not exhaustive and do not necessarily represent a general understanding that women have. There might therefore be a wealth of further information that can be garnered by studies that delve into specific health issues. Not all focus groups and key informant interviews were recorded, and none were directly transcribed, however two or three team members took notes during each focus group, identifying each woman participant by number. A consensus from the team was drawn in typing out and summarizing each focus group and interview.

REFERENCES

[1] Kruegar, Richard A. Focus Group Methodology
(http://www.tc.umn.edu/~rkrueger/focus.html).

[2] Nickerson, Nate. Schematic for Women's Health Needs Assessment. January 2006. *unpublished.*

III. Results and Key Themes

During the one-month duration of interviews, 182 women were interviewed. The average age was 36, and the average number of pregnancies was approximately four. The average pregnancies are lower than the DHS estimates (6.1 children per woman between 40-49 years of age) because of the larger age range of our study that included women aged lower than 40 years old.

Table 1. Descriptive statistics of participants (n=182).

	N	Range	Minimum	Maximum	Mean	Std. Deviation
Pregnancies	182	12	0	12	3.96	3.201
Births	182	10	0	10	3.27	2.688
Children living	182	10	0	10	3.04	2.537
Age	182	68	12	80	36.64	15.872
Household population	182	19	1	20	7.20	3.160
Years of study	181	20	0	20	4.13	4.387

While the women were easily able to respond to most questions in the demographic interview, such as owning a TV or how many children were being schooled, basic information such as age was difficult to assess. Many women did not know their exact age and rounded, as shown in the graph below. They preferred to round to numbers that were even or multiples of five. The younger the woman, the more likely they were to know the incomes in their homes and their age and years of schooling.

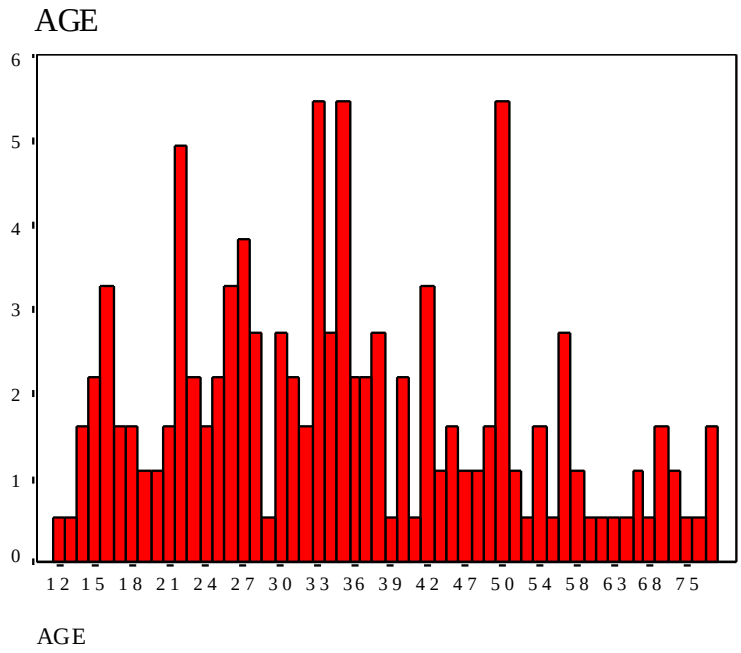


Figure 1. Age of participants (n=182).

Age had an interesting affect on the dynamics of the focus group. Younger groups (15-20 and 21-34) were more likely to give lists and impersonal responses to the focus groups. If they gave stories, they often depersonalized them, speaking of women in general or women they knew. Older groups (35-54 and 55 and above) gave their personal stories. The older women focus groups would often last more than half an hour longer because women would share their stories. Also with age there was a trend in technical knowledge about disease and prevention. While many of the younger groups could list many diseases by name, such as TB, HIV, anemia and hypertension, the older groups were

less able to do so, with the oldest women not knowing the names of any diseases. The same trend existed for knowledge of preventive methods and locations to access health care and health information. The oldest groups consistently said they knew no prevention methods, and one woman said "if we knew, we wouldn't be sick." And when asked where they could go, the oldest women often said, "only Jesus" or "only God." The oldest would say that the only help they had was that people would listen to them, but that there was no one to help them. The youngest groups however could list NGOs and hospitals and clinics such as Volontaire Development Haitien (VDH) and FOSREF, which both work with adolescents and reproductive health, Milot and Pignon, two private hospitals, La Fossette, a privately run clinic and Clinic Fort St. Michel and Justinian, Hospital, the public clinic and hospital. They would also speak of hygiene, preventing risks that lead to HIV/AIDS and STIs through condoms, abstinence, fidelity and family planning, cleaning the home and food of polluted and dirty air, water and dirt, and keeping away mosquitoes and flies as preventive methods to sustain good health. Interestingly, the younger groups also talked about regularly seeing a physician or nurse as a way to maintain health.

Another discrepancy between the groups was their source of contact (Table 2). Many of the groups were either found at health centers or religious centers. The groups that were based at health centers had more knowledge of specific illnesses, prevention methods, sources of health information and knowledge of where to seek healthcare. The groups that were religiously affiliated were less likely to speak openly about traditional methods or sexual promiscuity (especially in personal or acceptable terms). The group of young restaveks was an outlier in the focus groups because they focused on personal injuries and fear as their themes in their problems and health issues. They knew very little specific information on illnesses, prevention or health information. The differences in the groups of women often set the tone for the entire discussion, making each distinct and allowing a breadth of issues to be discussed in different contests.
Another bias found in the group discussions was the preoccupation with the elections that occurred on February 7th and the insecurity that increased right before them. The groups that were held in the last days of January were the most likely to focus on insecurity and political instability as problems and sources of problems that they had.
The focus groups and their information are listed below:

Table 2. List and description of focus groups (n=17).

Age Group	Date	Location	Religious Bias	Health Bias
15-20	1/18/06	Sacred Heart Nutrition Center	Catholic	Yes
15-20	1/30/06	Catholic Alphabetization School for Restaveks	Catholic	No
15-20	1/25/06	Fort St. Michel TB clinic	No	Yes
20-34	1/23/06	Baptist Church	Christian	No
20-34	1/26/06	Sacred Heart Nutrition Center	Catholic	Yes
20-34	1/29/06	MOFAPA, Petite Anse market vendors	No	No
20-34	1/27/06	Graf	No	No
20-34	1/23/06	Baptist Church	Christian	No
20-34	1/25/06	Fort St. Michel TB clinic	No	Yes
35-54	1/27/06	Fort St. Michel TB clinic	No	Yes
35-54	1/25/06	Sacred Heart Nutrition Center	Catholic	Yes
35-54	1/25/06	Fort St. Michel TB clinic	No	No
35-54	1/23/06	Baptist Church	Christian	No
35-54	1/27/06	Graf	No	No
35-54	1/31/06	Central Market vendors	No	No
55 and over	1/23/06	Baptist Church	Christian	No
55 and over	1/24/06	Sacred Heart Nutrition Center	Catholic	Yes

None of the women declined from being interviewed or participating in the focus groups. Many often wanted to stay longer and asked if there were more opportunities to participate. Overall they were both interested and enthusiastic in participating. Often women would open up emotionally in the focus groups with either anger or sadness and prompt the group discussions to become more intimate and personal. Through these interactions, the focus groups were richer in content, which allowed for a breadth of understanding, yet made it difficult to reach saturation in the interviews as they were so diverse in their topic focuses (determined by the group dynamics). Below are listed the main themes that occurred across all discussions.

3.1 Issues of Empowerment

Each focus group and interview was inundated with phrases that started with "I can't…" along with comments such as, "I am useless to the children", "I cannot take care of my children" as well as "our hands are empty". While the context of many of these comments was in speaking about caring for others, the women also spoke about not being able to find jobs, not being able to leave a man, not being able to afford any basic needs. These comments regarding inability to act outnumbered comments regarding lack of material items. While some women (especially the adolescents) would frame complaints as "there is no food" most women would frame it as "I cannot find food" or "I cannot grow food." This self-reflection in their comments, along with comments such as "we women are never taken into consideration… there is nothing for us in this society," made obvious the pervasive issue of disempowerment among the women in Haiti. "It's not the woman's fault, she did not choose this."

Along with their sense of disempowerment comes a sense of isolation. They feel there is no one to help them but God. They say there is nowhere to go. They feel isolated, especially as and with women. "Only between women can we say these things," a woman said at a focus group. And even though they might find some strength in women – each focus group included claims such as "there is no solidarity" or "there is no unity" and "no one listens … no one asks us."

3.2 Poverty

The women spoke about systemic poverty in their community. "We have a crisis. Parents look to their children for help and their children look to them, but everyone's hands are empty." The women said there was no support structure, no one to hear their complaints, no one that could help them.

In every focus group and individual interview the recurring theme of lack of money was present. This lack of money was connected to each of their complaints. They reported that they can't eat, sleep, have a home, go to school, find jobs, buy water, or access healthcare because of lack of money. Many asked for handouts, while even more were interested in acquiring jobs or improving their health so that they could make money. Admitting that success in the job market is impossible, they often described cycles of poverty such as the following:

1. "no money, no food, mother can't work, no money…"
2. "a man abandons a woman with children, she must find another man to help support, who leaves her with even more children…"
3. "if we don't have good health, we cannot make money"
4. "if we have bad health, we cannot work, so we cannot buy food so we have bad health…"

3.3 Humiliation

Both women and providers alike spoke about being embarrassed and humiliated. Women found their choices for income generation embarrassing. "No one respects a servant or a woman who sells on the street," one woman said. Doctors spoke about being embarrassed at the facilities they had with which to offer care. Both women and providers were embarrassed in front of the international community. Exacerbating the humiliation is that both women and providers indicated that they once were proud, that Cap Haitien used to be a beautiful city with many resources, but that it has worsened. Women further complained about being humiliated at Justinian, either by doctors or nurses, because they either could not understand their ailment, or were not respected.

3.4 Differences between provider and women perceptions

3.4.1 Understanding of health

Providers believed that women would define health primarily as being able to work, and not being sick. Only one provider, the psychologist, mentioned that some women might say they won't feel good unless those around them feel good. "They don't see the whole physical, psychological, economic aspects to health," one doctor said. Another doctor blamed education, "It's only the ability to work that they see as important … They're not educated, how could they know?" However, women were very comprehensive in their definition of health. Women indicated basic health issues such as having clean water, food, being healthy, having good respiration, as well as some descriptions expected by the providers such as being able to work. But women also mentioned health issues such as being able to go to a doctor regularly and have access to medications prescribed, to not have stress, to have peace, to not have violence, and to be able to sleep, "to have good health in our thoughts." In all, women brought up mental health, infections, issues of access and public security as health definitions. Additionally women spoke about how to have good health was to be rich and to have money would help them to be healthy. Providers, therefore, generally underestimated the breadth of women's definitions of health.

3.4.2 Traditional Medicine

"You know if they come to see you," said a doctor, "that they've already been to someone else." All of the providers indicated that traditional medicinal practitioners were the first health provider to be consulted. "They've already tried teas, baths, and more – and if you disagree with what the traditional healer told them, they won't do the remedy you prescribe," said another doctor. A third doctor voiced concern about women seeking traditional healers: "The traditional remedies are a waste of their time, money, and it delays them getting care." Generally providers of occidental medicine spoke negatively of traditional methods and claimed that almost all women sought traditional methods first. Interestingly, however, one doctor said, "even if us doctors don't believe in them – if nothing works, we sometimes seek traditional methods as well."

Women, on the other hand, largely claimed that they seldom consulted traditional healers. They explained that they knew traditional methods (specifically teas and baths) from their parents or grandmothers (usually women). They spoke of going to the marketplace to buy teas or medications off the street. But many of them, when discussing buying medications of the street, claimed they did so because of the lower cost and higher accessibility. Most women's groups used negative comments about traditional healers. One said, "The medicine at the hospital heals you, the traditional methods make you stink." Another said, "They do no tests in traditional medicine – they do not know what is really wrong and are not trained to heal." So while there might be reasons why they'd first take traditional methods (such as teas), they generally claimed that they didn't consult traditional healers. And for curative medicine, they generally said they would seek occidental healthcare if access and

funding to do so were available. “If we have money, we go to the hospital, if we don’t, we stay,” one woman explained. Accordingly, the only reason mentioned as to why a woman would seek a traditional healer was price and that traditional healers give credit.

IV. Basic Needs

The first component of human security is a sustainable sense of home. This assumes that immediate needs are provided for – which is often, but not always the case in Haiti. However, while most immediate needs are provided for (families often have access to some food, some clothing and sub-par shelter), a *sustainable* sense of home is often not achieved. Hindering the sustainability is instability of access to food, clothing and payment for housing, and overall, access to income –which is often the root cause of this instability. This chapter will focus on the following basic needs:

1. Food
2. Clothing
3. Shelter

These basic needs are generally grouped together. In each focus group women stated that they could not feed, clothe or house their children. One woman's comment typified the women's statements: "I don't have a husband, I don't have work, my children can't find work, I can't pay for my house, I can't feed my children, I can't send them to school, I can't clothe them …"

Larger socioeconomic issues play a significant role, specifically in the inability of women to generate income to feed their families due to nation-wide economic and political stability issues. Many women would speak about their inability to fulfill basic needs and attribute the cause to the inability to generate income, gender discrimination, unemployment and the disorganization of the country.

This lack of basic needs has exacerbated these issues by breaking apart families and communities as mothers give away their children and family members migrate looking for work or better living conditions. Many women spoke about either housing other's children or giving away their own children as well as spouses leaving for employment because of the lack of basic needs. Therefore the women's inability to fulfill the first component of human security, a sustainable sense of home, directly inhibits the second component of human security, sustainable sense of community.

To fulfill basic needs, some concerns about income generation were brought up repeatedly by focus group members. Many women said the pursuit of 'sexual lifestyles' is an option to provide food and clothing for themselves and their families. Although no woman personally admitted to practicing sex-for-pay, the repeated naming of this concern seems to indicate that it is an alternative income generation method that women choose. Sr. Rosemary Fry agreed with this assertion stating that she knew of women in her program that would come into more money without explanation and that she supposed this was the reason. This, although a method of garnering basic needs, will be discussed further in the socioeconomic and health chapters where the focus will be on the consequences of these actions on women's health.

Many providers, when interviewed about women's problems and specifically health problems, focused on socioeconomic issues without mentioning basic needs. The providers generally indicated that it was lack of money, jobs and gender inequality that created the most prominent barriers to care. Specifically, doctors and women's rights activists did not speak about the basic needs of the women – many did not bring up nutrition, clothing or housing at all. The providers that were the able to speak to the lack of basic needs were health workers that were less likely to be doctors and more likely to be nurses or NGO-representatives: Dr. Jean-Jacques (ObGyn – the only doctor), Sr. Rosemary Fry (a Canadian nurse who has worked in Haiti for over 20 years heading an integrative nutrition program for women and their children), a matrone (traditional birth attendant), and nurses from Justinian Hospital as well as Fort St. Michel Health Clinic. However, even when mentioned,

providers generally indicated socioeconomic underlying causes for the lack of basic needs while women generally focused on their inability to fill their basic needs.

Many of these unmet basic needs are widespread and cut across socioeconomic classes. Hospital professionals and patients face the same difficulties. There are no toilets in the clinics, and only a few [intermittently functional] at the hospital. There is no stable source of electricity in the hospitals or clinics, no food and no water. The nurses had not been paid for the few months preceding the interviews and stated that the problems the women have, they have too. One nurse said "I send my children to school with nothing to eat," followed by nods of agreement. The issues of unmet basic needs, therefore extend past the poorest into the middle classes as well.

One doctor was concerned that women's pursuit of basic comforts for their family – specifically food and housing – delays their seeking of healthcare. "They see those factors before their health," he said. He states that the mismatch of priorities between health professionals and women patients is an oversight of the medical community. Physicians encourage women to prioritize health care, while women will inherently prioritize the needs of their households. Health programming must be sensitive to the priorities of the beneficiaries to create effective programs that fulfill their needs.

4.1 Food Nutrition:

> Extreme poverty, combined with political, social and economic instability and recurrent natural disasters have exposed large sectors of the population in Haiti to food insecurity. Young children, pregnant mothers and lactating women are especially at risk.
>
> For many years, Haiti's economic deterioration and subsequent natural resources degradation, have undermined the population's fragile health and nutrition status and put a great strain on peoples' coping mechanisms. In 2004, the situation was further exacerbated – first, by the political instability which culminated in the removal of President Aristide and his Lavalas-government, and then, severe flooding.
>
> - World Food Programme, 2006

DHS surveys have consistently shown that the worst levels of malnutrition (measured by weight by age) in children, as well as adults, have been in rural areas and the northern region – the departments of the Northwest, Northeast and North [2]. The diminishing amount of available agricultural land due to high erosion, overuse, and deforestation reduces the capability of Haitians to rely on sustainable farming. While temporal trends show an overall increase in human nutritional status in Haiti – each period of political instability and environmental crisis has been accompanied by a worsening of most health standards – including those in nutrition [12].

4.1.1 Priorities of Women Beneficiaries

The issue of food insecurity, while being what is merely one of the many insecurities Haitians face, was a priority mentioned repeatedly in the women's focus groups held in January in Cap Haitien. The main themes of food insecurity were:

1. Children's hunger and malnutrition
2. Personal hunger
3. Cycles of poverty related to food
4. Food access and health
5. Agriculture

4.1.1.1 Their Children

A recurrent theme in the interviews with women was the primary responsibility they felt for their children. While the interviews were centered on questions regarding women's health, almost all of the answers women gave referenced their children's wellbeing. This supports the notion that women put themselves last in terms of feeding, clothing, and seeking care for themselves. One woman interviewed stated, "I feed the children and have nothing to eat – and often I can't even feed the children."

Exacerbating this is the rising prices of food. Whether it is an actual increase in prices or a decrease in the women's ability to buy food, many women were concerned that they could not afford the foods they had been able to buy before. "For my first child, I had a great reception with milk and coffee, now I can't even buy a bottle of milk," one woman said. Women specifically mentioned the increased costs of rice, milk and salt as indicators of their decreased access to food in general.

Child nutrition is an indicator of nutritional status of women [5, 8]. Women often feed themselves last, will seek healthcare for their children first, as well as take on most of the manual labor around the house. Therefore, child nutrition can be a useful tool to assess women's nutritional status [5, 8]. Many nutritional health indicators showed improvement coming into the year 2000 concurrent with the growing stability and national infrastructure capacity to develop social services.

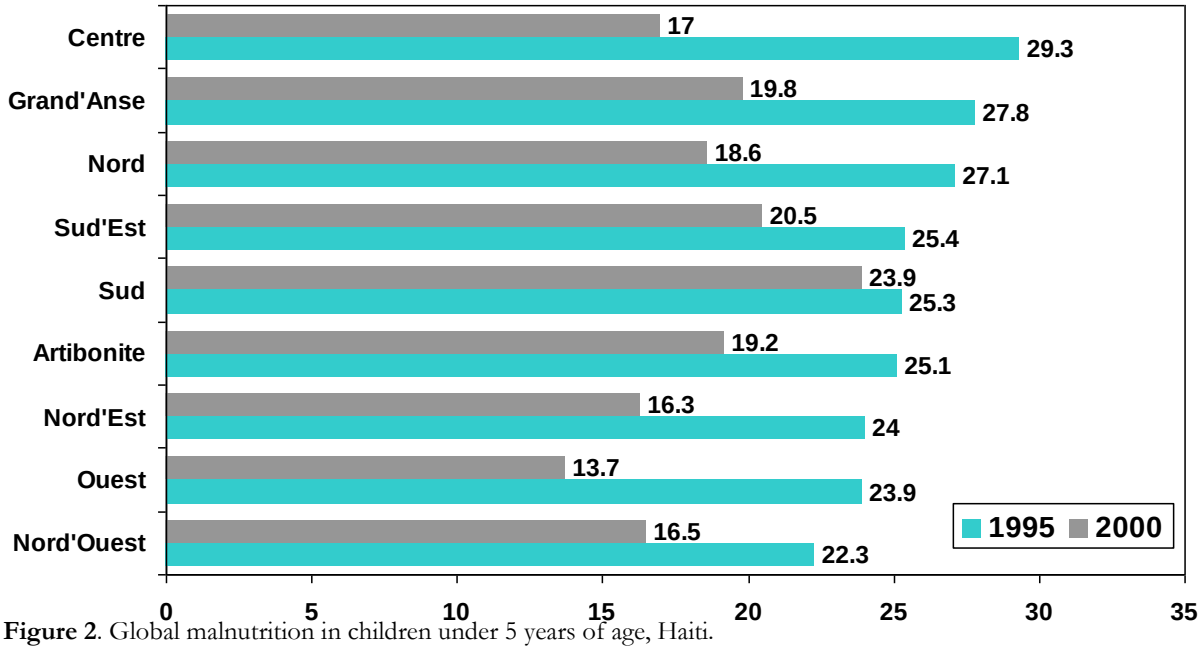


Figure 2. Global malnutrition in children under 5 years of age, Haiti.
1995: Analyse de Situation Sanitaire 1998. MSPP-OPS-UNICEF Cap Haitienital Consul
2000: Enquête de Mortalité, Morbidité et Utilisation de Services EMMUS III-2000

However, between 2002 and 2003, Cuban medical workers with PAHO noted an increase in protein malnutrition in all departments save the North-East, the South and the South-West [6]. Figure 3 shows the change in kwashiorkor and marasmus within the one-year period indicated by the Cuban medical workers.

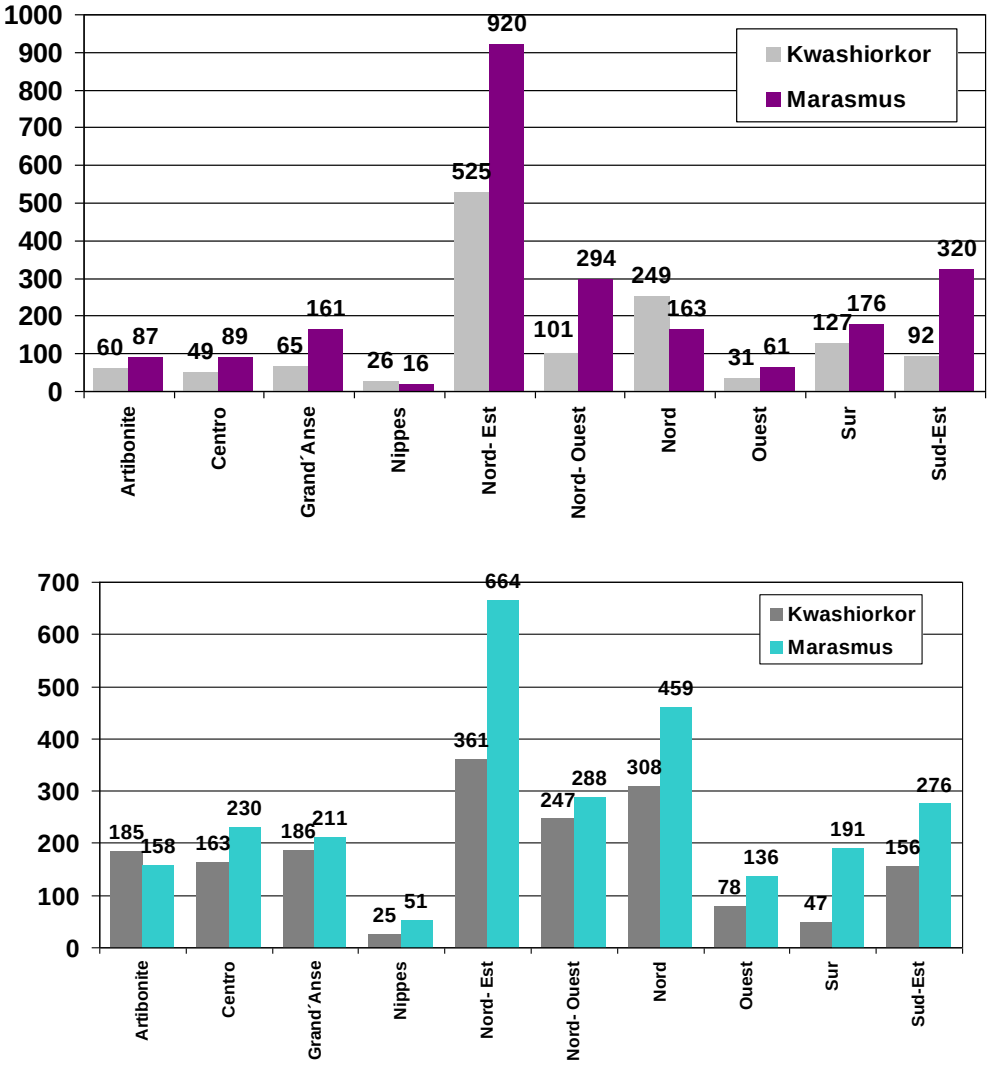


Figure 3: Malnutrition: Number of cases in children under 5 years of age *detected by the Network of the Cuban Cooperation*, by department, Haiti, 2002 (above) and 2003 (below).

With noticeable fluctuations, the overall trend in nutritional status is towards improvement. Malnutrition persists however, and research has been conducted to discern the main causes of this persistence. Kwashiorkor (a protein deficiency) and marasmus (general energy and calorie deficiency) are the most common types of malnutrition seen in Cap Haitien. Marasmus presents a more serious health threat as a severe total calorie-energy malnutrition. Devin and Erickson (1996) found in their research that malnutrition in young Haitian children was most significantly correlated to the number of children in the family (the more children the higher prevalence of malnutrition), roof type (as indicator of socio-economic status – those relatively poorer had increased malnutrition), time interval between children (the closer in age the children are, the lower the nutritional status), and the type of alternative caregiver (male alternative caregivers exacerbated the effects of smaller birth intervals on malnutrition) [1].

4.1.1.2 Personal hunger

Although concern for their children was generally their primary priority, women complained of hunger throughout the interviews. Comments ranged from "everything is worse when I do not eat," and "I suffer because I sleep without eating" to "I am dying of hunger." The severity of the

complaints varied, but the issue of personal hunger came up consistently in the interviews. Only once, however, did a participant say "give us food." This comment may have been made regarding the meal that was fed to every participant during the focus groups.

In women's health, one of the most important nutritional conditions is iron-deficiency anemia (IDA). Severe anemia causes complications with pregnancy, labor (decreases chance of surviving complications of pregnancy (i.e. hemorrhage)), as well as overall health. IDA is often the result of the synergistic effects of lack of access to appropriate food, infectious disease, eating habits, and chronic infection with worms or other parasites. Children's anemia is often a good indicator of the prevalence and severity of anemia in the community [15]. In Haiti, 53% of school-aged children have anemia [14] and 42% of children 2-5 years of age have specifically IDA [15]. Only 45 percent of women surveyed in EMMUS III in 2000 had no type of anemia (>12.0 g/dl), with 30 percent having light anemia (10.0-11.9 g/dl), 15 percent moderate anemia (7.0-9.9 g/dl), and 3 percent severe anemia (<7.0 g/dl). Women in the north are slightly less likely to have any anemia – 51 percent versus 55 percent - which might be in part because they are twice as likely to have fortified foods, including iron-fortified supplements as well as iodized salt (24 percent versus 11 percent), but fortified foods are still starkly lacking [2]. Higher access to fortified foods may be because of the easier distribution within an urban area and that Cap Haitien is a major port in Haiti.

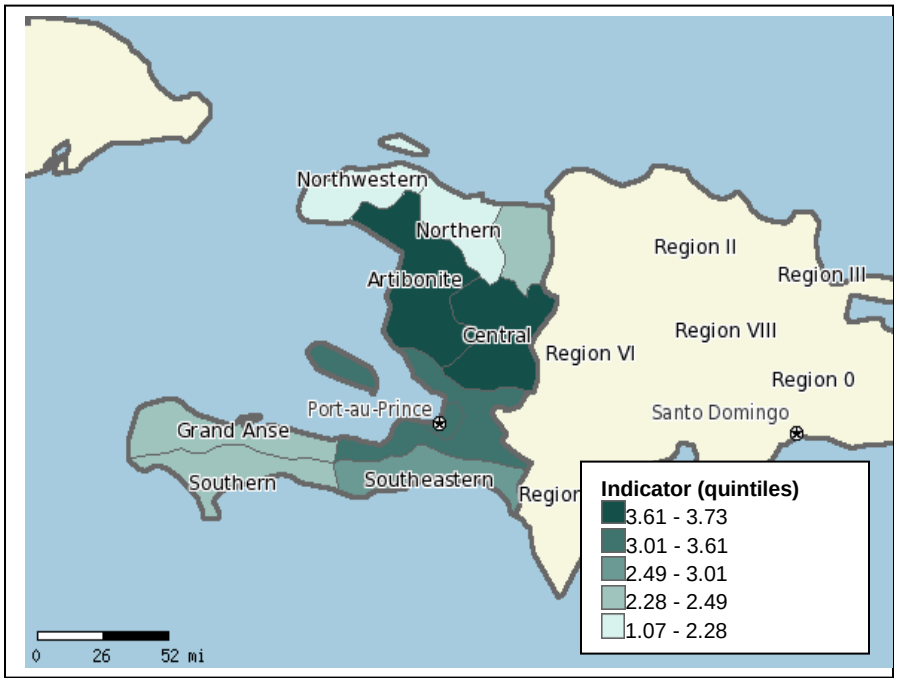


Figure 4: Percentage of women age 15-49 classified as having anemia. Hemoglobin levels are measured in grams per deciliter (g/dl). Women with <7.0 g/dl of hemoglobin have severe anemia, DHS 2000 (*DHSstatmapper, accessed May, 2006)*

Another important issue that had been noted by providers and beneficiaries was the increasing rates of chronic diseases in which nutrition plays a large factor. While there are higher rates of malnutrition in the northern department, there are lower rates of obesity in the northern department than in other areas of Haiti. Obesity is less common in the north with only 19 percent of women having BMI over 25, while all of Haiti has a rate of 26% [2]. One doctor cited that as many as 30% of women he sees at the hospital have a BMI lower than 18.

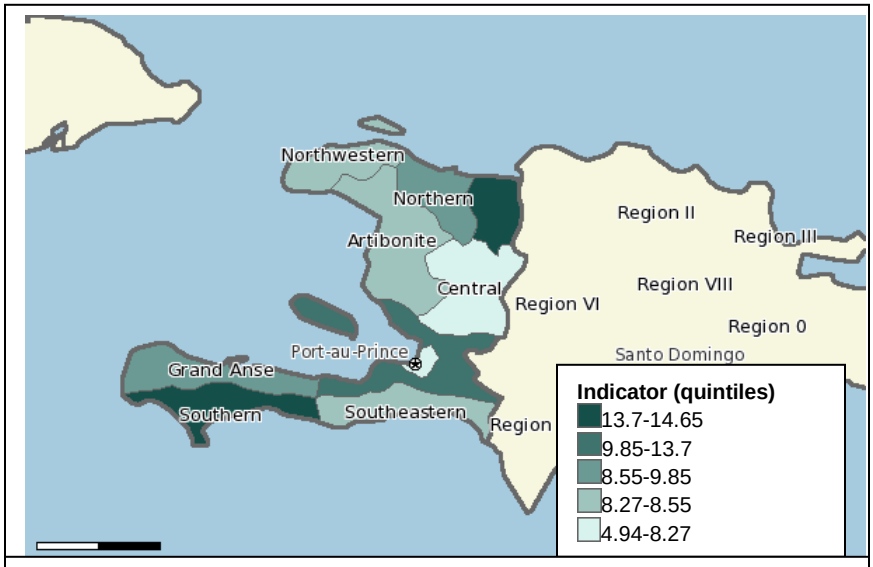


Figure 5: BMI <18.5 (underweight) in women (15+) by department, DHS 2000 (*DHSstatmapper, accessed May, 2006)*

Chronic energy deficiency is self-reported in 14 percent of the northern women's population [2]. This chronic malnutrition (whether micronutrient or energy deficiency) decreases the functional capacity of women, who are frequently the sole head of the house, often working to support their children, and often caring for 4-6 children at a time.

4.1.1.3 Cycles of poverty related to access to food

A third theme that came up was the interconnectedness of the women's need for food, their wealth and their health. Women identified with the following: "If my mother can't eat, she can't feed the children, she can't work, so she can't get money to feed the children." The cycles of poverty they identified generally included lack of food as exacerbating poor health and therefore impeding them from finding work. Finding less than optional alternative work was also brought up: "Famine makes women sleep with someone for money, they get pregnant and take medications to have abortions."

When asked why they have problems with food, women pointed to poverty. One provider extrapolated on the women's cycles of poverty connected with food: "Malnutrition is prevalent in Cap Haitien because of the level of poverty. Many people come to the city hoping for a better life but there are high unemployment rates. Women who go to the market encounter difficulty because everyone is trying to sell the same things in the streets. Exacerbating the effect of their poverty is sexual promiscuity, often causing women to have several children with different fathers who do not support them. This pattern continues as women seek other men to support them." These macro-level causes of food insecurity – poverty, migration, crowding and lack of fertility control – are all themes mentioned in each aspect of the women's struggle to fulfill basic needs.

4.1.1.4 Food and health

In terms of health, women connected not eating well with having fevers, stomach aches, inability to sleep, infections and dizziness. They linked food with anemia, diabetes and kwashiorkor by name. Diabetes is colloquially called "sucre" – the French/Creole word for sugar. Anemia is called "light [or thin] blood." Women also stated that they could not take medications without eating, and that since they had no food, they could not take medications. Lack of food, in this instance, may be viewed as a barrier to treatment.

When defining health, almost all focus groups identified "eating good food" as one of the main components of health. "I get headaches when I do not eat and cannot sleep" one woman said. Fortunately, it seemed as though some nutrition information has been disseminated well because all focus groups expressed how important it was to prepare and store food hygienically and a few women could identify specific nutritious foods (fresh fruits and vegetables). However, knowledge of how to prepare food superceded knowledge of what foods to eat.

"Very few people know about nutrition. And even when we tell them that the child is malnourished, it's because they are eating bad quality, not bad quantity most of the time. They don't see the distinction of the quality of the food – they only see the quantity," said a pediatrician.

4.1.1.5 Agriculture

This nutritional information that women seem to know, however, is accompanied by frustration on the part of most women in their inability to buy food (lack of job and money), their inability to find 'local foods,' which they prefer, and their inability to do agriculture because of lack of land and agricultural inputs. Some women and teenagers mentioned that they work the little land they have but do not have enough land, or none at all with which to grow crops for their families.

4.1.1.6 Alternative caretakers

Nutritional programming in Cap Haitien, therefore has a head start in the knowledge base of the women, which generally seems to be passed from information sources such as: their mothers, the radio, trucks with bullhorns and community health workers. However, women, while the primary caretakers, are not the sole caretakers of the family. Alternative caretakers are generally either older women (grandmothers), younger girls (older sisters) or fathers or younger boys (older brothers). Research has shown that when women leave their children with male alternative caregivers, their children are more likely to suffer from malnutrition or undernutrition [1]. Devin and Erickson further explain through doing interviews with men and women in the community that underlying reasons for this discrepancy may be either from 1) decreased understanding of what constitutes nutritious foods by men (while women seem to have a firm grasp on what foods are good), and 2) male caregivers will more often leave the children alone. Therefore, a woman's ability to feed her children is also linked to nutritional education of men. Alternative caretakers must be educated in nutrition to help the woman caretakers feed their children.

4.1.2 Approaches to Nutritional Programming for Cap Haitien

The recommendations are broken into two sections – those aimed for the improvement of community health based on a trickle-up approach (i.e.: targeting the children and the woman's ability to feed her children) and those aimed at women's specific nutritional issues.

4.1.2.1 Women's Nutritional Programming:

Anemia

Anemia is one of the few health conditions women cited by name in the focus groups. Almost all groups brought up anemia as a health issue, as well as its colloquial name "light blood." Women seemed to have some strong conceptions of anemia; many relating it to food, most relating it to headaches, dizziness and fatigue.

Anemia is positively correlated to poor birth outcomes and iron supplements have been shown to decrease maternal mortality due to anemia [17]:

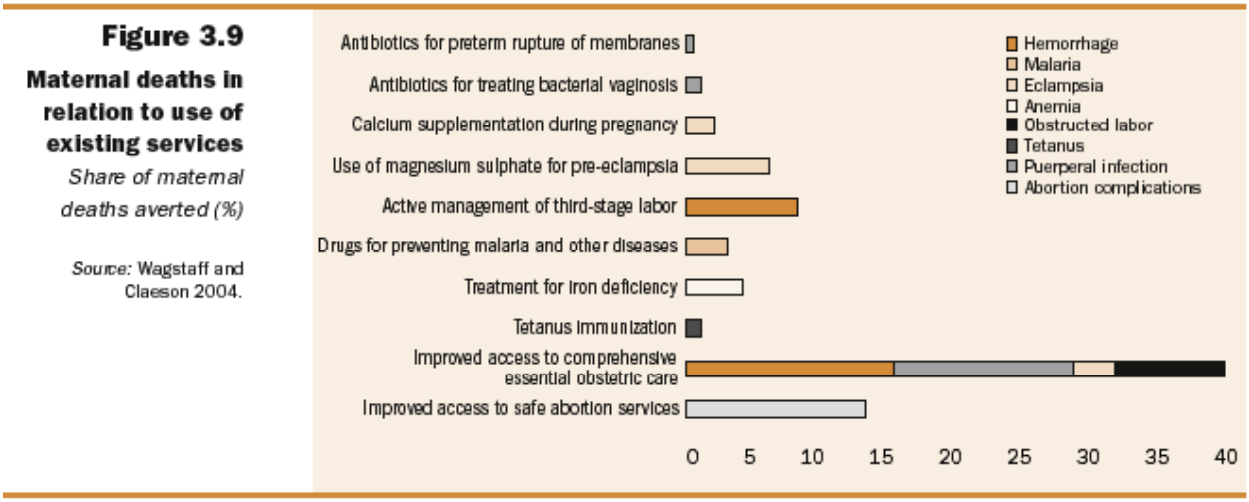


Figure 6. Share of maternal deaths averted (%) in developing countries by intervention (Wagstaff and Claeson, 2004).

Iron fortification is recommended by WFP – and generally incorporated into food provided by WFP or through supplemental iron packets that are distributed by NGOs through UNICEF efforts [3, 12]. Direct iron supplementation with pills is often the protocol for one month of pregnancy [12]. However, as a provider stated, many women do not know what pills or supplements they are taking and cannot identify what they are for. The lower prevalence of anemia in the north may mean that services for anemia in Cap Haitien tend to be better than those in the rest of the country or it may be due to the increased ability of NGOs to work in the urban setting of Cap Haitien.

Shastry and Weil (2002) found that anemia (using cutoffs of 12.0 g/dl for non-pregnant women and 11.0 g/dl for pregnant women as the thresholds for anemia) is directly correlated with wealth. Differences in national rates of anemia in women (15 years and older) explain 1.3% of the log variance of income per capita when comparing different countries [11]. This underscores the importance of providing iron fortification for women to increase their capacity to work and participate in the local economy.

Iodine Deficiency

Goiter is not only common with women in Haiti, but thought of as normal. Women don't go to the doctor for goiter until the growth inhibits their function or becomes too large and possibly embarrassing. Providers stated that they often see women with small, but visible goiters who do not see it as a problem - it is not even found to be esthetically unpleasant. The general programming recommendation is iodized salt – which does exist in Haiti, but is not yet widely accessible. Twenty-four percent of families in the northern department use iodized salt [2] – but it needs to become the standard salt and priced at low enough prices so that women can buy it. The increasing price of salt was often used in women's arguments that life had become more expensive – "even salt, one goblet (a Haitian measurement roughly equal to a large coffee mug), it's five [Haitian] dollars (equal to one dollar)."

Diabetes and hypertension

Although diabetes and hypertension will be discussed further in the health chapter, the women often linked these conditions to foods. In the case of diabetes, the relationship exists specifically in its name, the French/Kreyol word for sugar, 'sucre.' Women brought up diabetes specifically as a problem of older women, generally along with hypertension. A few women specified staying away from sugary foods as well as fatty foods as a preventive measure to stay in good health. One

provider specified how women did not understand the difference between carbohydrates, fats and proteins, and believed diabetes was only related to sugar.

Two medical doctors in Haiti, one a cardiologist, the other a family practitioner brought up the increasing trend in chronic disease in the patient populations they treat in Haiti, and specifically detailed the increases in diabetes, hypertension, cardiovascular disease and obesity. One doctor pointed to the lack of education about menopause leading to women's increased weight gain in old age. There is definitely opportunity for education within these areas that will be further discussed in the health chapter.

Breastfeeding
A matrone (traditional birth attendant) said "when we tell them to breastfeed exclusively for six months, they can't even do that, because they cannot take care of themselves." In her practice, she sees that many women who cannot find food discontinue breastfeeding early.

Exclusive breastfeeding in Haiti, which is the behavior most associated with reduced infant morbidity and mortality, is far less than the six months recommended by WHO [6]. Unfortunately, many women in Cap Haitien cannot breastfeed due to either malnutrition or possibility for HIV transmission. Women expend more energy during lactation and generally this additional energy is garnered through increased nutritional input or movement of fat stores within the body [13]. In a population where women suffer from malnutrition and where there is food insecurity, breastfeeding can further exacerbate their poor nutritional state. Studies have shown that multinutrient supplementation for breastfeeding mothers may increase the nutritional value of breastmilk [9]. Nutritional programs encouraging breastfeeding that also conduct nutritional assessments of mothers and provide them with supplementation are needed.

Empowerment in nutritional programming
A nutritional program that takes into account the beneficiaries' contextualization of problems must include empowerment in the model for programming in Cap Haitien. A nutritional program which provides aid solely on case-finding may provide women and children food without considering and addressing the primary interest of the participants – their inability to acquire food and feed their children (and afterward themselves). What they are asking for, what they are prioritizing through their language is the need for empowerment in nutritional programming.

While some direct aid is necessary – specifically with acute cases of malnutrition, there must be empowerment to facilitate long-term effectiveness. Nutritional education must be integrated into the school system, health workers must integrate nutritional education into their programs (through presentations to TB patients or mother's groups that already exist), and income-generation must be facilitated by credit or cooperative forming through which women can earn the means to gain food access.

More importantly, women beneficiaries must be involved in every step of the process: determining priorities, programming, and setting indicators for monitoring and evaluation [4]. Empowerment indicators such as nutritional knowledge, as well as ability to choose and access different foods must be included as program benchmarks.

4.1.2.2 Community Health
Currently, most of the treatment of malnutrition in Cap Haitien is done by the World Food Program and consists of giving dry rations once a month to families with malnourished children, pregnant women, breast feeding mothers and those with TB or HIV. To include empowerment and the needs

the beneficiaries stated, nutritional programming in Cap Haitien must integrate the following: 1) a child-focused approach, 2) case-finding of malnourished women and children, 3) nutritional supplementation (as necessary), 4) education, 5) income generation, 6) agricultural opportunities, 7) involvement of alternative caregivers and 8) involvement of the public sector.

Child-focused Approach
Because of a woman's priority to feed her children before herself, one cannot combat malnutrition in women unless their children are provided for. Women will feed their children first, then the adult males, and themselves last. A nutritional program focused on improving the nutritional statues of children will likely have a positive trickle up effect on women's nutritional status.

Case-finding
Nutritional programs must have outreach centers that women can take their children, or themselves for nutritional assessment. The most common forms of nutritional assessment in Haiti are weight-for-age, weight-for-height, and upper-arm circumference, all which are easily measured. Educational programs to increase awareness of this service in the community should be created.

Nutritional Supplementation
Most nutritional supplements are imported to Haiti. They generally consist of either fortified foods from WFP or micronutrient supplements in the form of packets of powder supplements or creams. Effort should be put into using whatever local products are available for food supplementation along with efforts to increase the capacity of people to grow their own nutritious foods.

Education and Income Generation
The nutritional centers should form mothers groups, single women's groups and also men's groups to inform people about proper nutrition and hygiene and the health consequences of not following these practices. According to the US Army, parasites (especially amoebas, tapeworms, giardia, etc) are common in Haiti and can be consumed through improperly cooked foods [16]. While many women mentioned cleaning and cooking of food as a preventive measure, cooking methods should be included in a nutrition education program. These groups can also facilitate cooperatives for income-generation. Nutritional programs can include income-generation strategies as well as life-skills education programs (such as how to manage money) to facilitate the empowerment of their beneficiaries.

Along with creating groups to educate the adults involved in the programs, nutritional programs should work with schools to integrate nutritional education into their education system as well as encourage and facilitate the children in their nutritional programs to continue their schooling. Schooling will be further discussed in the socioeconomic chapter.

Agricultural Opportunities
Cap Haitien is the second largest and most densely populated area in Haiti. This leaves little room for agriculture and leads to some of the most expensive prices in housing and basic needs. In Cap Haitien, women form cooperatives for clothes making, tourist artistry, marketing (either foodstuffs or small soaps and other small items), and washing and laundering. All of these are used with microfinance schemes to generate income for the poor women in Cap Haitien. One industry that has not been explored is urban agriculture. CARE International has implemented urban agriculture programs in PauP, but it has not yet been implemented in Cap Haitien [7]. Urban agriculture creates the opportunity for the poor to use tires, baskets, kettles, pails, and other containers to grow vegetables in confined areas and thereby improve their health, nutrition status, and income [7]. By

training women in skill sets they can use to market as well as methods of urban farming – they would be even further empowered to feed their own families.

Alternative Caregivers
As reported above, male alternative caregivers are less likely to be educated in nutrition. Nutrition (as well as all household knowledge) is generally passed down through women. Creating men's groups as well as women's groups could give the opportunity for 1) education of nutrition for men, and 2) possible cooperative forming for income generation. Because women often leave their children with alternative caretakers it is important that not only the women, but also the men in the home are trained in nutrition, health and hygiene.

Public Sector
Konbit Sante, has hired community health workers with the MSPP, partially to do health education (not specifically nutritional education) throughout the area of Cap Haitien. In partnering with the MSPP, Sacred Heart, or another nutritional group could co-hire and use health workers to facilitate a) case-finding to identify malnourished women and children, b) nutrition education in communities and c) create women's groups that can be integrated into the program. Fortunately, the MSPP of Haiti is one of the government's most stable, decentralized and functional ministries in Haiti. The ministry is open to partnering with NGOs and health-NGO and MSPP partnerships are one of the most common forms of health structure in Haiti – comprising over 60% of their facilities [2]. Already, Konbit Sante has started a nutrition supplementation program in the pediatrics ward of the Justinian Hospital in Cap Haitien. Nutrition has not, however, been integrated into their community health workers agenda, and should be in order to decrease morbidity and mortality both from malnutrition itself as well as the opportunistic infections of increased susceptibility.

The Ministry of Agriculture in Haiti maintains inventory on outputs of agriculture in Haiti. Use of local foods would also increase community nutrition and women's satisfaction with food intake. There is little evidence that the malnutrition in Haiti is due to actual inability to grow food. Instead it seems as Amartya Sen has stipulated, that malnutrition is more an issue of entitlement and distribution than overall lack of food [10]. Just in the northwest (a rural area west of the northern department), agriculture is one of the main means of living (though decreasing with the inability to make a living and problems with erosion and land quality).

	Percent Area Cropped with:				
Crops	Inland Dry	Humid	Dry Plateau	Dry Coastal	Irrigated
Maize, Beans & Viv	6.5	18.7	17.6	35.8	14.1
Maize, Beans & Sorghum	10.6	2.7	3.7	7.5	5.5
Beans & Viv	15.8	21.4	26.9	23.9	12.8
Maize & Beans	5.5	9.2	9.2	3.0	8.0
Maize & Viv	4.0	5.6	5.5	4.5	4.4
Sorghum & Maize	23.7	10.0	5.1	0.0	5.7
Viv & Fruit	3.1	4.4	2.3	1.5	7.0
Beans & Sorghum	3.5	0.7	1.8	0.0	0.4
Only Viv	7.5	9.6	7.1	9.0	13.9
Only Beans	0.9	3.5	2.8	4.5	1.7
Only Sorghum	6.8	1.5	0.5	0.0	1.5
Only Maize	1.2	1.5	3.3	0.0	1.3
Only Peanuts	5.4	0.7	5.7	0.0	4.4
Only Tobacco	1.4	2.5	2.2	3.0	4.4
Only Orchards	0.0	0.2	0.8	0.0	0.4
Other	4.0	7.7	5.3	7.5	14.1
Total	100.0	100.0	100.0	100.0	100.0

Figure 7: Crops grown in the northwest department, 2002 (Baro, 2002).

While the crops are lacking in fruits and especially vegetables, there are grains as well as protein-rich foods that are locally grown in Haiti. Working with the Ministry of Agriculture, both to aid in the urban agriculture sector, educating families on what to grow and when, as well as helping families with providing agriculture inputs (through private-public partnerships) could provide families with increased empowerment to feed themselves.

4.1.3 Summary

The predominant barriers to nutritional programming in Cap Haitien will be the centralization of the government, the lack or instability of infrastructure, the high unemployment and lack of income-generating opportunities, as well as the environmental issues with crowding, and degradation of soil quality. This will make nutritional programming, at least in the short-term, highly dependent on outside funding and NGOs working within the Haiti. Cap Haitien has a few characteristics that make it somewhat easier than other parts of Haiti for nutritional programming: being the second largest city in Haiti, having an international airport and being one of its largest ports. Therefore, it is fortunate to have more government presence as well as access to international aid through water and air transportation.

Nutritional programming must take into consideration the needs and contextualization of needs of the beneficiaries. In doing so, they can begin to respond to the needs of women to feed their children. The programming must be holistic and include education and income-generation. Only

through integrative nutritional programming can the nutrition status of women increase over time with decreased chances of recurring malnourishment.

4.2 Clothing

The youngest groups of women (15-24) were the only focus groups that prioritized clothing, specifically shoes. They identified clothing as a personal need. The middle-aged women (25-54) referenced the problem of clothing as an inability to clothe their children. The older women (55+), while not identifying a need for clothes, mentioned the past textile factories that provided jobs for women but no longer exist. What factories did exist closed (generally due to national instability), decreasing employment opportunities for women. Older women also mentioned the need of young children for "pretty things" and their inability to provide them with clothing and shoes and some voiced concern that "the young have sex to pay for clothing."

Opinions on donated clothing vary greatly depending on the interviewee. Members of the focus groups identified an increase in used clothing, both donated from other countries and resold by women in Cap Haitien. Providers such as Dr. Dani Dugue and Sr. Rosemary point to this influx of used clothing donations from abroad as one of the undermining factors in women's local sewing industry. While this may be the case for many, some women in the focus groups use the used clothing as a method of income generation, by selling it in the markets. However, those that sell the used clothes said they find it hard, if not impossible, to sell the used clothing. No women, however, complained about the free or cheap used clothing. This was actually the only issue that was said to have gotten better in one focus group: "now we can get cheap pepe [used clothing]."

4.2.1 Clothing and health

While women mentioned the need of clothing their children, they did not connect the need for clothing to health. Shoes, however, were repeatedly brought up as a preventive health measure. Women knew that they should wear shoes at all times because of what they called 'microbes' in the dirt. They did not specify worms or infections, but it seems that they have acquired some knowledge on the environmental hazards of not having their feet covered. Hookworm is common in Haiti and the US military specifically warns their soldiers in Haiti to keep their feet dry, cleaned and covered specifically for parasitic and fungal infections [16].

4.2.2 Recommendations

Should it become possible, investment in the textile industry and a reopening of textile factories would create a number of job opportunities for local women. In the meantime, NGOs that donate shoes and clothing should work with cooperatives that already exist and alongside microfinance programs. Therefore, instead of drowning out the local economy with free goods, the donations can be used to facilitate income-generation as well as cooperative-building.

Picture by MaryAnn Dakkak. January 2006, Cap Haitien.

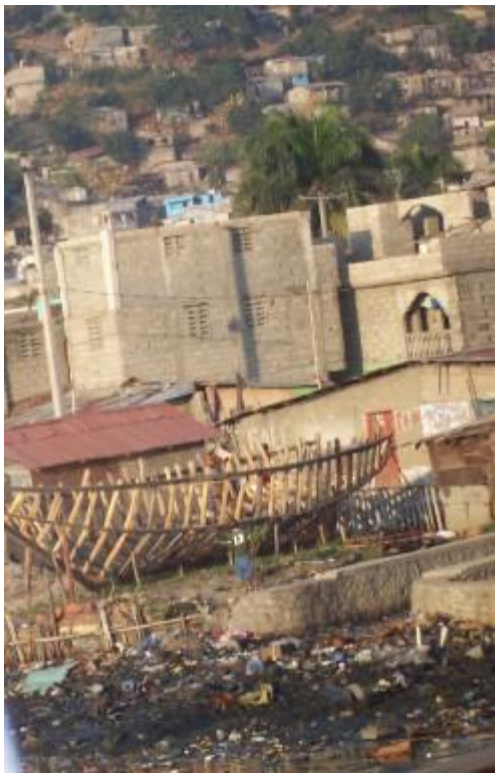
In terms of health, special consideration must be given to the need for shoes in the community. As a preventive health measure, women should be educated not only on how to prevent "getting microbes from the ground", but they should be educated on what microbes are in the ground, how they enter the foot, and given recommendations on keeping feet clean, dry and covered. NGOs should,

if the resources are available, donate shoes alongside the health education program.

4.3 Housing

Housing is highly variable in Cap Haitien. There are more affluent neighborhoods where the upper classes enjoy personal generators that provide constant electricity, along with either personal or semi-personal wells that provide water (not potable but usable for cleaning). However, this is a small minority of the population of Cap Haitien. Most inhabitants of Cap-Haitien live in housing where there is no electricity, no running water – no water accessible at the home at all generally, and no toilet facilities (if they live in houses at all). Many women stated that they could not afford rent, had been evicted (children stating "they kick you out and close the door on your face"), and that their homes were in horrible condition: "when there is sun, it's fine, when there is rain, it's like being outside," and "when it rains or floods the children have to sleep in chairs."

Public water and toilets do exist – though there are not enough to supply the population. While 88% of all Haitians have access to water near or in their home, only 61% of Haitians living in the Northern department have access to water near or in their home. Along with the decreased access to water, there is also a decreased access to electricity – 22% of Northern Haiti compared to 34% in all of Haiti [2]. Many of the women interviewed use the ocean to do simple cleaning, attend to personal hygiene, use as a toilet, and as a garbage facility as well. This has obvious ramifications on the sight, scent and cleanliness of their beachfront and many women explain how they have no other options. They go on to explain how the unsanitary conditions give them bad health, make them worry for their children and make them unhappy.



Picture by M. Dakkak, Cap Haitien, 2006.

The women lamented the "dirtiness" of their living conditions, although they tried desperately to keep their living spaces clean. They said they could never walk barefoot, and voiced concern about flies, mosquitoes, flooding, litter, dust, etc. "Even when we clean, and the floor looks good, it doesn't mean it's clean – we shouldn't walk barefoot," one woman said. When asked for causes of the "dirtiness" of their living conditions, women brought up issues of crowding, the disorganization of the country, and the economy.

Cap Haitien outgrew its city lines over a decade ago and many of the shantytowns have been built on drainage areas and riverbeds [6]. According to the demographic interviews with the women, there is a lot of internal migration in Haiti to urban centers for work. This has caused the creation of urban sprawl and poor slums in the areas around downtown Cap Haitien (such as Petit Anse in the photograph to the left). Many houses in the slums are so small that all of the members of the household are unable to sleep at the same time. This problem doesn't exist only with the lowest classes, but the middle as well. "There is the problem of housing. The person has a tiny space to sleep, and it's full of people in the house. Sometimes they can only sleep in turns," one nurse said at Justinian Hospital. Another said, "it's expensive, dirty, it's unlivable, we live like sardines."

The poorest women, such as those in the groups interviewed, often don't have their own housing or if they do, have overcrowded houses. Their families are broken up into other houses of relatives or friends. "I tried to put my child in an orphanage, but they wouldn't take him, so I gave him to a friend," a woman said. In urban areas outside of PauP about 6.1% of children are living as 'restaveks' (servant children given away as infants) [2]. Or the opposite may happen - a woman houses children that are not her own. "I have 5 children who live with me, three are not mine, the mother left them with me because she couldn't pay," one woman said. It is reported that 28.6% of children living in urban areas (excluding PauP) live without their parents [2].

These parentless and homeless children create a subpopulation that may have different health needs. Specifically, a focus group of restaveks was the outlier in all of the women's interviews – as they prioritized different health issues and different causes, which will be discussed in the health chapter.

Insecurity has greatly affected housing. Almost every group (the youngest groups excluded) included a woman who said that either her house had been burned, had been torn down or robbed. Others said they had felt insecure where they lived and had to move, abandoning what house they had.

The problems of housing therefore lie in the various sectors: security, availability of safe housing in Cap Haitien, overcrowding and public services such as water, trash and electricity. Many of these issues will come up within the other chapters in which recommendations will be made.

4.3.1 Housing and health

It is common to have overcrowding in homes – one of the women interviewed had 14 people living in two rooms. Overcrowding increases susceptibility to waterborne, vector-borne and airborne diseases, specifically in areas where sanitation facilities do not exist (as is the case for most of Cap Haitien). Tuberculosis and malaria are endemic to Haiti and in the period of interviews in Cap Haitien, two of the six Haitien team members had malaria. The overcrowding of households mixed with no sanitation facilities and standing, polluted water directly affects the health of the population [18].

One of the ramifications of family and community breakdown due to unaffordable housing is the discontinuation of traditional knowledge – specifically health information. Many women stated that their homes were where they learned the basics of healthcare and prevention – specifically from their mothers. Therefore, if children are being given away or dispersed, the traditional routes of teaching are broken. This fragmentation of the family may also have mental health ramifications. One nurse said "children live without their parents, with little kids, psychologically there's no one for them to trust."

The lack of water accessibility is a serious health issue that will be discussed in the next chapter as well as the lack of sanitation in the communities. The women, along with saying they should wear shoes to prevent disease, also suggested cleaning their houses as a means of preventive health measures. Women, therefore, not only know, but also put effort into keeping their homes clean as a preventive measure for bad health. However, with leaky roofs, lack of solid floors and issues with flooding, there are many factors that are out of a woman's hands when it comes to maintaining a clean home.

4.3.2 Recommendations

Health education must incorporate disease prevention actions such as minimizing standing water and keeping households clean (and elevated where flooding occurs). Active case-finding must be

done for airborne infectious diseases because of the overcrowding and high immune compromised state of the malnourished in Cap Haitien. Medical staff must investigate what causes of disease exist in the household with the patient to inform them on what preventive measure can be taken. This will also increase the medical staff's ability to provide better care as their patients, having acquired better knowledge will hopefully use the treatment and prevention measures to decrease their burden of disease.

4.4 Conclusions

As the first component of human security, it generally follows that the fulfillment of basic needs in the home will be the priority for women over personal health. This was confirmed in the interviews with the women where the main concerns were the fulfillment of their family's basic needs, specifically food and shelter. For health programming to be effective, it must acknowledge and address the priorities and concerns of the beneficiaries. However, the underlying causes of symptoms or infections can often be traced to where they originate – in the home, in the food, in the water. Therefore while acknowledging that basic needs is a priority for women, health programs also need to address the health issues originating from those basic needs and address those issues in their education, nutritional and health programs. This will be further discussed in the following chapters.

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V. Public Services

The second component of human security is constructive social and family networks – in other words, a strong sense of community [1]. This piece of human security will be divided into two chapters – one on public services and the other in social and economic aspects which speaks more to social capital, income generation, culture and gender issues. The public sector is responsible for many aspects of community sustainability that are often taken for granted in the developed world. Following a brief overview of overarching aspects of public services in Cap Haitien, this chapter will discuss:

1. Roads and Transportation
2. Electricity
3. Water and Sanitation
4. Public Security

The public sector topics stated above not only affect health through accessibility to healthcare centers but also can pose as public health hazards in the community. The status of roads, transportation and public security can lead to increased injuries and deaths by violence and accidents. The lack of access to potable water and sanitation facilities increases consumption of unsafe water, increases standing water, and therefore increases the prevalence of water-borne diseases and parasites as well as increasing mosquito populations that transmit malaria. In Haiti, the Ministry of Public Works is responsible for road conditions, and water and sanitation and the Ministry of Justice is responsible for law enforcement and keeping peace [2].

In most countries, the public sector is not only responsible for many country-wide initiatives such as those listed above but also acts as a safety-net for those in need. However, this is not the case in Haiti. "We have women who come in with children, one who is very sick, and the woman cannot handle the situation, it's not uncommon for these mothers to tell you, 'let the child die because if I spend all my money on this child, I won't have money for the others.' It's awful because they have to choose between their children. That is one of the gravest problems – that there is no insurance for these gravest health problems," explained a doctor. In one focus group the need for social security was an issue and in another one the issue was the lack of authorities that they can go to for problems. The international NGOs are left to attempt to fill select gaps, which are many (discussed further in the internationalization chapter).

Currently Haiti has no tax system for its citizenry and so there is little state revenue. The government is almost completely dependent on international sources for money and supplies. The infrastructure that does exist has currently been unstable and unreliable. As already mentioned in Chapter 4, the employees of the Ministry of Health had not been paid for a few months prior to interview – and employees stated that payment continues to be unreliable which has helped perpetuate the problem of absenteeism as well as decrease the morale of employees in the public sector.

The public sector has intermittently attempted to provide income-generating opportunities for the community of Cap Haitien. The women in the groups, while complaining about not being able to participate in commerce and not having factories for work, also mentioned a recent public works program. About three years ago, the government paid for women to clean the city on a weekly basis, but this program was discontinued when funding ran out.

Many of the overarching issues that affect all public services in Haiti stem from the instability of the government, which leads to unreliable infrastructure, disorganization and lack of enforcement. "Because the services are not available in a continuous fashion, the people lose their trust [in those services]. The system loses its credibility," one provider said.

Political instability

Haiti is a "failed state" according to the UN and most media groups (including BBC and the New York Times). The Failed States Index (Figure 1) indicates 28 failed states as of 2006 [3] of which Haiti is ranked number eight. It is the only country along with Colombia (ranked 27) that is a failed state in the Western Hemisphere. The Failed State Index uses indicators such as: *de-legitimization* of the state, progressive deterioration of public services, widespread violation of human rights, sharp and/or severe economic decline, chronic and sustained human flight, demographic pressures, etc.

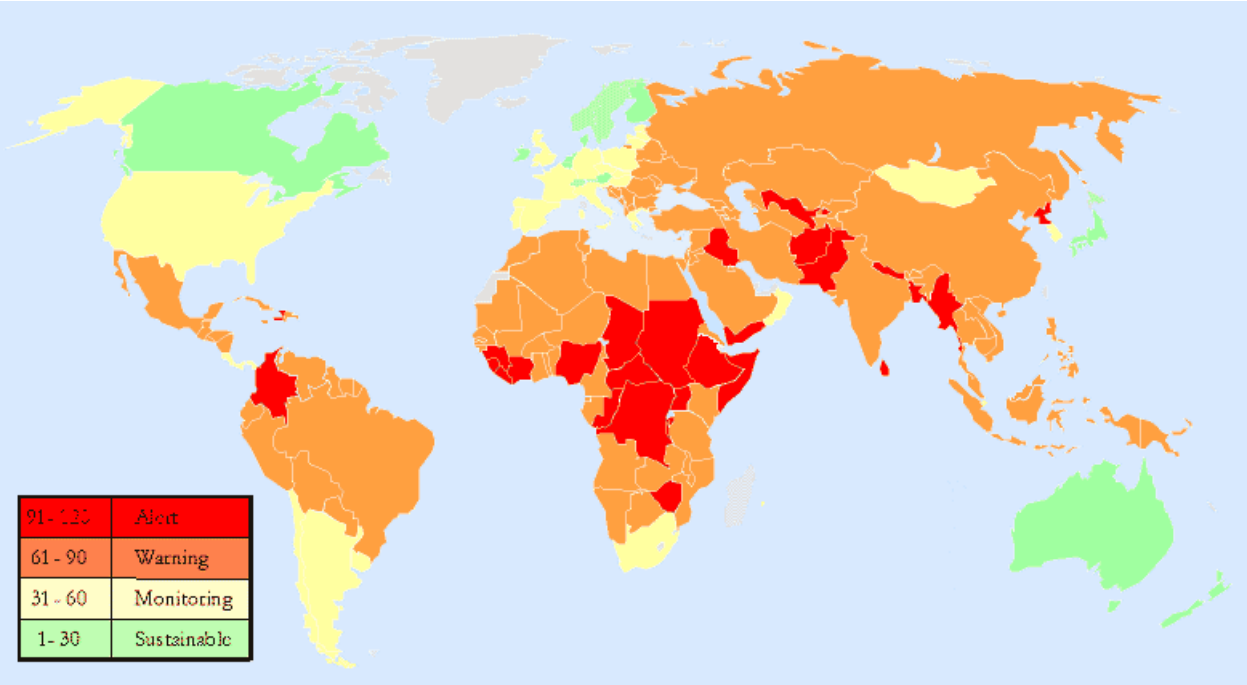

Figure 1: Map of nations by their level according to the Failed States Index [3].

Both women and providers indicated political instability as a cause for all lack of services in Cap Haitien as well as the increased violence in the community. One doctor noted the indifference from the state to restructure and help the people. Women linked the lack of political stability with mental health issues: "The state of the country creates a lot of stress," one woman said.

The women repeatedly spoke of the "disorganization" of the country as well as citing "no president," "no authorities" and "no help" as priorities. The women's primary concern was with the violence, many giving stories of rape, robbery of homes, muggings, and destruction of property – specifically houses. Interestingly, women pinned many hopes on the upcoming elections (that were completed in February 2006). "Before anything, there must be change," one woman said about the government. Another said, "I am proud because the day of the elections is coming and it will bring change." For what type of programming they would like to see, one woman said "I want to see a government that is responsible in all circumstances." A psychologist said, "Politically I'd like to see a stable government, more organization and infrastructure for women – a state that's responsible." This puts enormous pressure on the incoming government to create change that will directly affect the population.

Enforcement

The creation of laws and government bodies to provide and ensure public services are not effective without follow through and enforcement. The laws that are in place are often not enforced. Issues that that came up included rape, the morning-after pill and abortion, all are illegal, but none is strictly enforced. Rape remains common according to both providers and statistics. The morning-after pill is sold on the streets. Abortion although less common in hospitals and clinics now, remains common in the community, according to providers who work at the hospital who see women with complications from illegal abortions in their practices. Some providers did mention some available services, however. For rape, there is a tribunal in Cap Haitien that women can go to. The women go to the judge, the judge gives them a paper for their attacker and the man must pay damages. What often ensues is even more violence, if anything at all, providers indicated. All three of these issues will be discussed further in the security portion of this chapter and the socioeconomic and health chapters.

One telling story occurred at the hospital during the duration of the interviews. A woman came in hemorrhaging from an illegal abortion. A man was with her whom we assumed to be her husband, or her boyfriend. The family came after an hour. They told the man that if she died, that they would kill him. The residents and nurses overheard, but nothing was done when the woman died and the family left holding the man between them. Justice is often taken into their own hands as Haitians don't find venues in which to get the justice they feel they deserve – even if there is a form of justice guaranteed by law.

5.1 Roads and Transportation

According to the women in the focus groups, issues of transportation ranged from cost, distance and security. Cost was the most common reason for women not being able to travel to their health center. PAHO has reported that road access as well as transportation are key issues in access to care in Haiti and showed similar findings as the focus groups: The most important problems of access for women are the following: lacking money for treatment (75%), transportation/road access (35.8%), the distance to the facility (33.2%), and fear of going alone (22.6%) [2]. In a few of the focus groups, women identified fear of travel as a reason for delaying access to healthcare. This issue was also timely as the interviews were conducted 1-4 weeks prior to the elections and that during the period of interviews a curfew was imposed and shootings outside the city were reported.

An example of security issues delaying access occurred at the hospital during the duration of the interviews. A man came into the hospital one morning with a newborn infant. When asked where the mother was, he answered that his wife had gone into labor at 10 pm (after curfew) and that no taxi drivers would drive into the city (although he could pay them). The woman started hemorrhaging at 2 am and died that night.

Specific to Cap Haitien, however, distances to medical facilities are often shorter, since it is an urban center with more roads, taxis and health centers – PAHO reports that access in urban areas outside PauP is 62-87% compared to roughly 40% in rural areas [2]. The lack of access to care in the rural areas also impacts the health centers in Cap Haitien. One doctor said that they are not only overcrowded by the population in need in Cap Haitien, but by people from the surrounding rural areas that commute for their healthcare. When asked what programs should be concentrated on, many focus groups identified creating dispensaries or health clinics within each neighborhood because of the distance to their nearest health facility.

Recommendations

When ongoing treatment is needed, health staff should ask the patient whether they can access the health facility, and if not, the reasons for their inability to attend their needed appointments. Although the health staff might not be able to directly aid in these issues, it is important that the staff acknowledges this possible hardship and does not prescribe care that cannot be completed. They should work with the patient to create a prescribed plan that can work for them to the best of their ability.

For populations that have little or no access, or people who are not able to come into the health facilities, there should be mobile clinics or community health agents that visit specific communities at scheduled and regular intervals. This will facilitate case finding as well as broaden the population base for health education.

5.2 Electricity

Women complained that there was no electricity in their homes or in their community centers and this lack of electricity was listed as a top ten priority in many of the women's groups. "We knock our feet together in church because we cannot see," one woman said. Lack of electricity was mostly an issue in terms of lack of lighting according to the women's complaints.

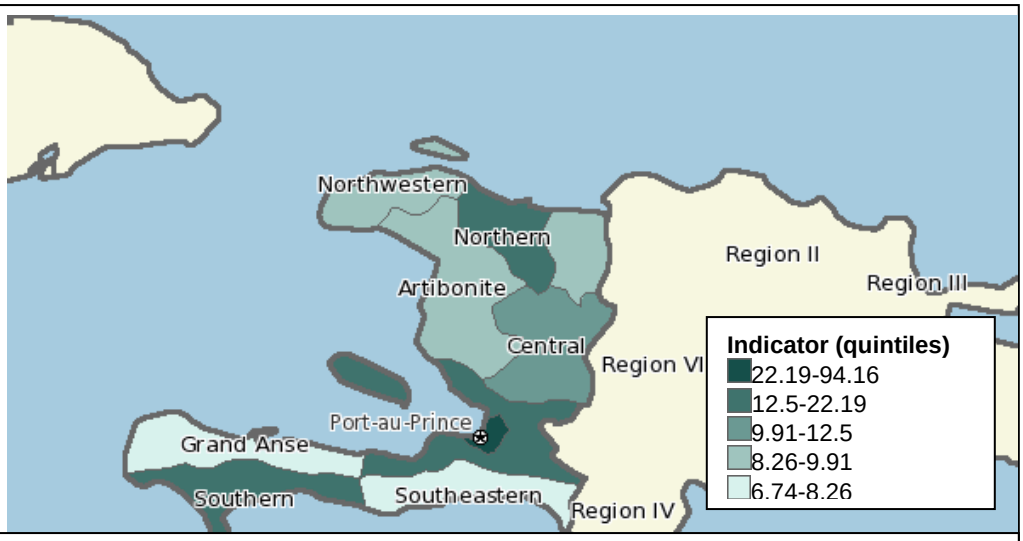

Figure 2: Households With Electricity: Percent distribution of households by housing characteristics, according to region. [5] *(DHSstatmapper, accessed May, 2006)*

The northern department has the second highest prevalence of households with electricity (22.19% of households) after the metropolitan area of PauP (94.61% of households) (Figure2) [6]. It is important to note that access to electricity does not always translate into availability of electricity; in most areas – even with access – there is unreliable availability.

According to USAID the main cause of Haiti's lack of electricity is lack of fuel [7] Thus far, Haiti's electric system is public and is run by Electricité d'Haiti that has failed to use and maintain existing power sources [7]. There has been a push, however to privatize the electricity in Haiti, though nothing has been done since 2004 to change the electricity access.

Unfortunately, the healthcare system is also subject to these electricity shortages. During the month-long duration of the interviews, at Justinian Hospital in Cap Haitien, the hospital-wide electricity (supplied through the public electricity services) generally stopped at 10 a.m. and returned in the middle of the night. There were a few generators that were run for the most important areas of the hospital – specifically the surgery rooms (of which there are two) and often the Family Practice offices (but not the patient rooms). But there are instances, when even the generators do not

function because of lack of fuel. "At 8 p.m. there is no electricity in the hospital. The doctors and nurses just sleep at night. In the middle of surgery the electricity will stop. We still operate without electricity sometimes," one doctor explained. Nurses at Fort St. Michel, a public health clinic in a suburb area of Cap Haitien, complained that they had no electricity at their health facility either. This lack of reliable electricity also prohibits many medical technology improvements at the hospital, such as a standing blood bank.

Recommendations

The most critical piece in terms of healthcare is the lack of electricity in health facilities. A few doctors pointed out that Konbit Sante had been actively working to improve the electrical problems in the hospital but that they have thus far not been able to do anything substantial about the electricity problems. More effort must be put into maintaining fuel supplies for generators as well as prioritizing electricity usage. There must be an effort to list all the facilities within Justinian Hospital and then categorize them into priorities for receiving electricity. According to this list, the generators already there, as well as new generators should be distributed. Another important piece would be to keep track of how much fuel is available and not to start operations when the fuel will run out, but to gauge what is needed and use it appropriately.

5.3 Water and Sanitation

Water and Sanitation includes: access to clean water for drinking and bathing, removal systems for human excrement, and trash collection systems. Water and sanitation is of key importance to health because of its link to disease. The lack of clean water accessibility and adequate sanitation is a public health hazard, especially with waterborne and airborne illnesses. In addition to these issues, there is also a problem with trash disposal– as there is litter on the ground, as well as the use of empty plots of land or beach land as disposal areas that drain into the local water sources. Women generally connected all of these environmental health issues: "We have no toilets, there's no potable water, there's trash on the streets, the mosquitoes, the flies," stated one woman identifying the key problems in health. Natural disasters exacerbate this problem with access to water and sanitation. Hurricanes have been the cause of destroying many water sanitation facilities as well as flooding whole communities [2].

Table 1: Trends in water supply and basic sanitation coverage levels, Haiti, 1990-1995 [2].

Service and location	1990	1993	1995
Water supply in the capital	53%	34%	35%
Water supply in smaller cities (72)	58%	40%	45%
Water supply in rural areas	33%	23%	39%
Basic sanitation in urban areas	43%	41%	42%
Basic sanitation in rural areas	16%	14%	16%

Figure 3: Households Using Piped Water: Percent distribution of households by housing characteristics, according to region. [5] *(DHSstatmapper, accessed May, 2006)*

Women in the focus groups prioritized water as one of their top 10 concerns consistently. They indicated lack of water being a problem in bathing, drinking and washing. They complained, "We don't have enough water to clean in." The lack of water to clean extended to laundry and dishes as women also said that they couldn't do laundry or dishes.

Women linked the importance of having clean water to health. They understood dirty water as a source of "microbes," and asserted repeatedly how important it was to wash hands before eating, after going to the toilet, as well as how important it was to wash foods. "We get infections because the drinking water is dirty – there are too many microbes," one woman said. In terms of hygiene, the women also indicated that they did not have enough water to clean with. "When we bathe in a bucket and clean our face and then our private areas, which are more fragile, we can get infections." Most specifically women cited unclean water as the cause behind sexually transmitted infections (STIs). "I have itchiness in my vagina," a woman said, "and it's because the water is polluted." Each time STIs were brought up as a priority of health, when asked the cause, women would refer to bathing with dirty water. Nurses at Justinian explained that women, when asked about STIs "think of the wrong causes," and identified specifically that women would "say it's the water they do their toilette in."

Some women also referred to a connection between drinking bad water and anemia. This link can be quite real specifically in cases of complex anemia where there is co-infection with parasites. However, some providers believe that women generally do not know that water could carry infection but that the knowledge is improving. "They don't have a concept of microbes – if it looks clean, it's clean. But now there's a lot of teaching in that area. For every child who presents with diarrhea, you automatically ask and do the teaching," she said referring to the hospital and clinics.

Some women understood that they could not visually tell the cleanliness of water. One woman explained, "Even if the water is pretty, if we put it through a machine, we see microbes." While many women indicated that they should drink "purified water," only one woman mentioned a purification method (boiling) as a preventive measure – indicating a possible area in which public health education may be able to improve the women's ability to access clean water.

The women generally had to buy water in order to assure its purity, but many of them explained that they couldn't afford to do so. Most women accessed water by buying it from a public well – however this water was not purified. Purified water is even more expensive. "We drink whatever we can, but we know it's dirty, it gives infections and makes our skin itch," a woman said. During the demographic interviews, when asked where they get their water, many women would answer and

follow up with, "but I should buy clean water" – indicating that they know where to find pure water, but that the price is their main barrier.

Access to clean water

Within the demographic survey, we asked the women individually where they obtained their water for their household. Only 1 woman had indoor plumbing and 7.6% had water accessible at home. The table below displays the most common sources for acquiring water.

Table 2: WATER: Source of water for women interviewed (n=182).

Source of Water	Frequency	Valid Percent	Cumulative Percent
Source	8	4.4	4.4
Public fountain	56	30.8	35.2
Paid public fountain	6	3.3	38.5
Bought	98	53.8	92.3
Well at home	13	7.1	99.5
Indoor plumbing	1	.5	100.0
Total	182	100.0	

The northern region is one of the driest regions of Haiti, with one of the starkest statistics of water availability. While 88% of all Haitians have access to water near or in their home, only 61% of Haitians in the northern department have access to water near or in their home. Comparing the Northern department with all of Haiti, there is less indoor plumbing (7% compared to 11%), less access to public wells (25% to 43%), and less access to outdoor water sources (29% to 44%) [6]. Over time, since 1990, there has also been a decrease in water supply in large cities outside of Port au Prince – from 58% in 1990 to 45% in 1995 (Table 1). This trend is occurring in all urban areas, while in rural areas, water supply is increasing [2].

Sewage systems

The most common forms of toilets in the group of women interviewed were outdoor latrines (if any). The women in the groups – particularly the older women's groups (55+) prioritized toilet issues. "It is impossible to urinate," one older woman said because of her decreased ability to squat. "To do what I need – I go to the sea. I go to the toilet and clean in the sea. I have a place for a latrine, but don't have the means to build anything," one woman said. There is no public sewage system in any city in Haiti. Access to basic sanitation has remained completely unchanged since 1990 [2]. Sixty-one percent of the population in the Northern department have no toilets (Figure 4) [6]. Within the sample of this study, only 38.4% had no toilet at home, with 26.7% not having access to any toilet whatsoever. This higher percentage of access to toilets may be due to the women living in an urban area. Even at the hospitals and health clinics there are neither toilets for patients nor adequate latrine facilities that are maintained properly, according to nurses.

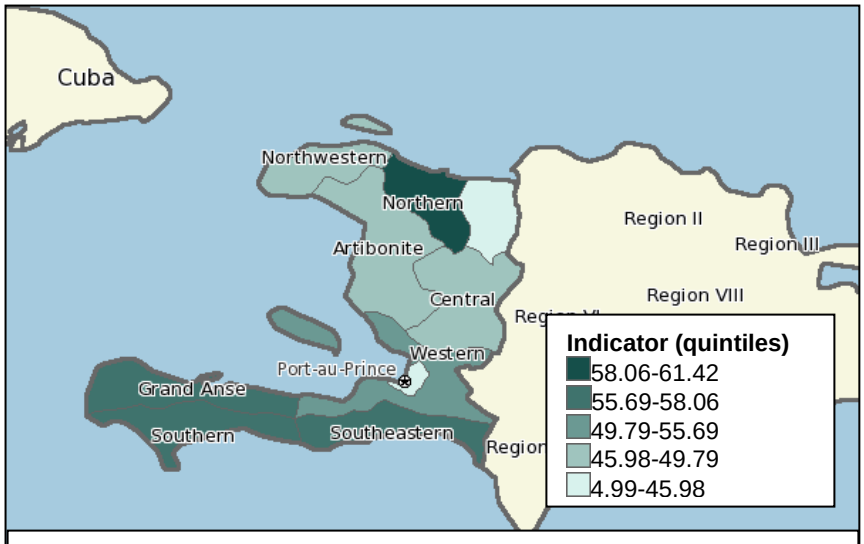

Figure 4: Households With No Toilet: Percent distribution of households by housing characteristics, according to region [5]. (*DHSstatmapper, accessed May, 2006)*

Table 3: Toilet facilities of women interviews (n=182).

	Frequency	Valid Percent	Cumulative Percent
None	49	26.9	26.9
Public Latrine	21	11.5	38.5
Latrine at home	106	58.2	96.7
Flush toilet	6	3.3	100.0
Total	182	100.0	

The lack of a public sewage system means that when women clean dishes, do laundry, or clean their homes with water, they dump it in the gutters on the street, in the riverbeds or on the beach. This creates standing water – an important public health concern, particularly with vector-borne disease such as malaria, filariasis and dengue that are endemic to Haiti.

Trash disposal

Women's primary concerns with trash were cleanliness, smell and health. "We live on the trash right next to the ocean," one woman explained. Specifically, women linked trash with respiratory infections – "We breathe badly because of the trash." When asked what are the causes of the litter and trash in the streets, rivers and public spaces, women brought up the government ("the state doesn't do its work") and overcrowding ("there are too many people, people leave the countryside to come into the city"). The condition of their living environment caused frustration in some women – as one woman said, "We can clean one day, but the next day there is trash again." They repeatedly spoke about flies and mosquitoes in their food, in their homes and how they brought in disease. Without a disposal system, trash often rots, collects and creates stagnant water pools in the streets, sewers, riverbeds and beaches that attract and create breeding grounds for insects and disease.

The nurses at Justinian echoed the frustrations of the women in keeping their living environments clean. They also spoke about the difficulty in keeping the hospital clean. Keeping the hospital clean, however, might have been exacerbated by the fact that the cleaning staff had not been paid for four months prior to the interviews done in January 2006.

Discussion and recommendations

"The government structure is not effective at getting information to the people," one provider said. It is necessary to increase the public health capacity to do education campaigns on water quality and purification systems as well as education on minimizing standing water near homes. NGOs and the public sector must invest in sewage and water systems to decrease the burden on the healthcare sector as well as the burden of disease to the population. At-home purification methods, such as boiling, iodine treatment and bleaching should be taught to increase the ability of women to clean water themselves for use. There are generally two methods of water purification – either filtration of particles out of water, or the inactivation and/or removal of microorganisms that cause disease. A nutrition provider explained that in her program, they teach them to use Clorox – 10 drops per bottle rum of water (a measure in Haiti) and to let it sit for half an hour. She claims that she wouldn't see most of the health problems she sees in her nutrition program if the children had clean water.

Specific disease surveillance, such as for cholera, amoebas, giardia, typhoid, other diarrheal diseases and parasites, and malaria should be implemented in order to identify bad water sources and map out where water facilities should be improved and/or where education campaigns need to be prioritized.

There seems to be some common understanding between providers (especially nurses and community NGO representatives) and women as they both echoed each others' frustrations at the

lack of electricity, security, transportation and waste system. However, no doctors brought up water and sanitation as health issues. Providers tended to neglect security as a barrier to care. Providers also underestimated the knowledge of the women and did not prioritize the issues of public services as much as the women.

Health staff should take the time to follow up with every patient by educating all patients presenting with water-borne disease about water quality and purification methods. Health staff should take the extra moment to ask the patient where they get their water and give recommendations to their plan of care based on what the patient can access.

5.4 Public Security

Haiti has had difficulty ensuring public security for more than a decade. Since early 1990's there have been two coup d'etats with interim governments that have been barely able, if at all, to maintain security. The most direct effect public security has on the health system is the increase of injuries due to rape, killing, shootings, fighting and other forms of violence [2]. Indirectly, insecurity can impede people from traveling to health centers, including providers themselves, as well as increase mental health problems.

PAHO conducted a study in 1995 of 1,705 families where 1,935 cases of violence were reported: physical (33%); sexual (37%) – with rape being 13% of that total; political (2%); social (2%); psychological (2%); and unspecified (25%). Most victims are young women (81% of all documented cases involved women aged 10-34) [2]. Therefore women take the brunt of the consequences of lack of public security. Insecurity, after food, water and health was the next prioritized health issue identified by the focus groups.

The main themes that came up during the discussions about insecurity were: the responsibility of the state, the fear of the women and that the violence is gender-biased toward women. It is important to note that although insecurity came up in some form in all focus groups, the closer to the elections, the more insecurity became a main theme in the discussions. Interestingly, when the women were asked what the causes were for insecurity they would answer both the political situation as well as unemployment. They voiced that if there were more jobs, there would be less insecurity. "Violence occurs because men feel stronger than women. When a man has a problem it is passed to women. The problem is often economic," said a woman's rights advocate. The women also linked insecurity to income when they were asked how things had changed since they were young. The most common answers were things are more expensive, and there is more violence and theft. The women's inability to find retribution within the justice system was brought up by the women, but even more by the providers.

Insecurity and health

Generally speaking, women said, "If there is violence, we cannot sleep." They said when defining health, that "if all is not well around us, we are not well," referring to insecurity. Another said, "Insecurity is horrible, I walk scared." Without using the term "mental health", the women indicated that the violence in the community was creating fear and psychological unrest. One woman said, "It's the situation of the country that makes us have problems. It's not women's fault, we did not choose this." They specifically cited insecurity as a barrier to seeking healthcare as well as being a detriment to their health.

A psychologist said that women were not being passive, and that she believed that they were trying to create peace, but that the social violence, the robbery, mugging and rape, has been very difficult for the women. Specific to Cap Haitien, she said that while most women have often thought it

normal for violence to occur in Port au Prince, there is a certain shock that has come from the increasing violence in Cap Haitien.

Rape

Rape has physical, psychological and social ramifications. Political violence and oppression typically lead to increased vulnerability to rape [10]. Specific to rape in Haiti, women who are raped are more likely to experience lower incomes and higher STI rates [11]. Psychologically, rape can have a traumatic effect that can leave women with psychological issues, fear, depression and hopelessness. Socially, rape has often been used as gender-subjugation and has had larger ramifications on women's issues as a whole [12].

UNICEF reported that seven out of ten interviewed women (in 1996) indicated that they had been victims of violence, with the most common form being sexual violence – rape, sexual aggression and sexual harassment (37%), and 33% having been victims of physical violence – blows, beatings. Fifty percent of the aggressors (physical and sexual) were unknown to the woman. Sixty-six percent of women kept their experience secret: 32% from fear of social judgment, 22% for reprisal and 14% because of lack of legal measures [8]. In another study done in Haiti, a shocking 29% of women had not consented to their first sexual experience [9]. This corresponds to many of the women expressing the concern that young girls get raped and that they must not be out late.

Rape in Haiti occurs in two main forms – inside the home and outside the home. Women in the focus groups spoke about both forms of rape (domestic and out-of-the-home), but rape outside the home was brought up more often (rape inside the home will be discussed in the family section in Chapter 6). Women expressed fear of going to the market, especially in the late afternoon/evening: "The market close to here, after 8, we cannot pass through it, they rape the women." The women generally stop doing commerce at 5 because they are afraid of being out late. Younger women were more likely to speak of being fearful of being beaten and raped, while older women referred to it being a problem for younger women. Women closely linked rape to abortion, saying in many focus groups that women are forced to get abortions because they are raped.

Nurses at Justinian explained that they saw more women coming in having been raped due to the increased insecurity from 2004-2006. They said that there had been increased aggression, children stealing, and rape. Many of them were frustrated over the lack of resources for women who were raped. One nurse explained how it had been very difficult to find a doctor to tend to a young girl who had been raped and the doctor scolded the parent saying that the child should not have been neglected. The nurses continued to say that the stress created from insecurity creates hypertension and other health problems.

"Justice sees rape as a crime, but it is common – in the home, outside, and there's no legal assistance for these women," one provider said, "Public services doesn't encourage equality in the sexes." Another provider explained further that rape within a couple was both common and even normal, and that women he consulted have been raped but would not speak against their partner.

An interview with a women's advocacy group, AFSDA (Associacion Femmes de Soleil de Ayiti), revealed that many women do not seek legal aid because of fear that they will be raped or beaten again by the same aggressor. Even the women who work at AFSDA related stories about how they had been victims of aggression both in person and on the phone by men about their work in women's advocacy.

Theft

Interestingly many groups cited robbery as a problem for the young, not that the young got robbed, however, but instead, that the young were more likely to be robbers. The younger women (15-20) would say that young girls would take things out of their bags. Older women said that they wouldn't carry a bag at all because it could get stolen. "In my neighborhood, if we leave looking clean, others think we have money, they will kill us for our money, and see that we had nothing," a woman said about how things had gotten worse in her community. Others chimed in saying that they could not carry money around and that they got kidnapped for money.

"I can steal," one older woman said, "but I'd rather ask." In Haiti, the poor tend to rob from the poor. While most of the kidnapping is directed towards richer families, petty theft is common. The motivation from thievery may come from desperation of needing money for basic necessity or from systemic violence that is politically motivated. While a few women spoke of the contemplation – the actual desperation – leading to theft, many of these women have been victims of robbery.

Destruction of property

The most common destruction of property women spoke about was vandalism to their houses. Some of them told stories about how their houses had been burnt down, how rebels had torn them down, and how the government had torn them down – the most common being breaking and entering and then burning. "People enter houses, they kill, they destroy," one woman said. This destruction of property has exacerbated the housing issues discussed in the previous chapter as women often have to break their families to find adequate housing for their family members or become homeless.

Killing and injuries

"We hear gunshots, people are dying," one 15-year-old girl said. When asked what program would help the most she continued, "Stop the people from dying." Fear was the most common reaction the women had to the increased physical violence in Cap Haitien. Some spoke of shootings, of not being able to go out in the evenings, and of the curfew that had been imposed the last week of the interviews. One doctor said that before they had had one shooting every two to three months, but that there was now about three gunshot victims a month that came to the hospital.

"We only live by the compassion of God. They kill randomly – even the retarded people. Before this would happen in other places, but now it happens here. The children are afraid to go outside, even those who were in Port au Prince have come back here," an older woman said. This concern, of children coming back from PauP was a concern for many of the older women, whose children had left to find work in PauP. Many felt that the insecurity that was increasing in Cap Haitien was also coming from PauP.

There had been a shooting and killing in the street a week before an interview, and the women brought it up. A few days later, a man came into the hospital one day with a machete sticking out of the side of his head. This in itself created a lot of discussion at the hospital. The next day, this same incident came up in a focus group as one of the women had seen the man as well. News of violence was very quick to spread in Cap Haitien and it seemed as though women took on many of the stories as reasons to be more afraid of the insecurity in their community.

Discussion and recommendations

"The solution will come with education, starting at the base, the youngest, working with families to learn tolerance and reject violence," one provider insisted was the key to stemming the social violence in Haiti. "There needs to be help from both the public and private sector," a psychologist said. NGOs that work with women's rights, gender issues, violence and income-generation must

cooperate to increase the security of people in Cap Haitien. From the health perspective it is important that health providers discuss the origins of disease and injuries with their patients – to give them at least an ear to speak to. Many women discussed how no one would listen to them; no one inquired as to what they feel and think about their own problems. If women present with injuries or STIs, the health provider should speak with them about where they believe their malady came from, and what they can do to prevent it or change it. Health providers should also be able to refer women to justice systems or women's groups should they need them.

Specific to rape – there must be local efforts into creating income-generating opportunities for women – especially if, as women believe – women have been participating in transactional sex, putting themselves at additional risk. In terms of STD prevention, local initiatives in Cap Haitien will not succeed unless they work against gender inequality and economic vulnerability; therefore, women's empowerment through education and income-generation must be included so that women can have power in sex and use preventive measures (this will be discussed more in the next chapter).

The success of any local intervention is unfortunately dependent on Haiti's macro-economic issues; therefore external humanitarian and development assistance will continue to be crucial to the success of interventions [11]. Through private/public partnerships, health workers can slowly alleviate the burden of both mental and physical health on women in Haiti. Even by just beginning to listen to the concerns of the women, providers can formulate better plans of care that are informed by the capacity, needs and priorities of the women.

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VI. Social and Economic Factors

The second component of human security is the cohesion of a community. Social and economic factors shape community needs. In this chapter the topics of community that will be covered are:

1. Money
2. Income Generation
3. Income disparity
4. Schooling
5. Gender disparity
6. Religion and Traditional Medicine
7. Social Networks

While income has the most direct effect on the women and providers ability to access and provide healthcare, income disparity can also affect the communication between patients and providers. Women consistently blamed their inability to access care on lack of money. "We get the prescription, as if it will spontaneously heal us, but we cannot pay, we return home to die," one older woman said. The providers, although generally able to access healthcare, also have difficulties accessing supplies to provide healthcare. Many clinics and providers cannot purchase necessary technology and therefore are not adequately equipped to provide the health services they would want to provide otherwise.

Gender power disparity was seen as a main source of women not accessing care. All providers indicated that for poor (and even most women in Haiti in general) women – husbands controlled their health and that women would defer all health questions and advice to their husband in the presence of health personnel. Some women also indicated that they could not seek healthcare because of men or boyfriends who either did not want to pay to access healthcare or did not want to take the time necessary. Another direct impact on health is the domestic violence and forced sex in the home that is common according to all providers and some women that directly affects fertility rates (positively) and STI rates (positively).

6.1 Money

"Women, as soon as they have money to live, they are cheerful, pretty and always happy," one nurse said. Money was generally mentioned in one of the first two phrases, if not words, in every focus group. Whether it was inability to pay for basic needs, the general lack of money, or the inability to pay for services, women often focused on their poverty status. Each problem confronted, be it food, healthcare, clothing, shelter, or schooling was always clarified or supported with a statement about their lack of money and therefore their lack of what they wanted or needed. Closely linked with lack of personal money, women indicated that the country's economy is a problem: "we cannot make money, the economy is a priority."

Providers also recognized the health access implications of the poverty status of the women. "Because these women are mostly poor, don't have work, there's no social security, so the women we see at the hospital – generally they cannot fix their medical problems," one female physician said. Women echoed this by their statements that even if they went to the doctor, they could not afford the prescriptions and tests. Subsequently, many of the women and providers (especially nurses) recommend programs that decrease prices for drugs, healthcare supplies and other barriers women face to accessing healthcare. A few women and nurses asked for free drugs and healthcare.

6.1.1 Money and Health

Every focus group and key informant interview indicated lack of money as a barrier to women seeking and getting healthcare. Providers also indicated that lack of money was a barrier to providing healthcare. "As soon as we have money, we go to the hospital, if we don't, we stay home," one woman said. Another responded, "We go to the hospital, the prescriptions lay in our hands, as if we'll spontaneously heal," indicating that she does not have the money to pay for prescribed medicines. A third commented, "I had to have an exam that cost 450 [Haitian dollars], the request stayed in my hand."

Women also saw lack of money as a risk factor for getting sick. "When we don't have money, we can have all kinds of illnesses," one woman said. Women said that if they could afford better foods, cleaner water and access to healthcare, they would have better health. Women also implicated the lack of money as a barrier for mental wellbeing. "If we are poor, we cannot be in good mental health," one woman said.

Providers concurred that the largest barrier to women receiving healthcare they wanted was lack of money. "The person won't go [to the hospital or clinic] because they don't have money. She'll stay at her house and have tea. If the tea doesn't work, she will borrow money to come to the health center," a nurse said. "And the longer they wait, the more expensive it is," another nurse said.

6.1.2 Cost of health

At the Justinian Hospital consultations are free, however there is a 4 Haitian dollar charge to get each patient's folder, which without; the patient cannot be seen by a doctor. Prescriptions and supplies, however, must be paid for. There are free ARVs for eligible AIDS patients, free contraception (with a 10 Haitien dollar consultation and initiation fee), and free TB treatment, however for most sicknesses treatment must be paid for. Patients who have free medications for one ailment generally do not have access to other medications without payment. Even for delivery, women must pay for any supplies, the bed, and any incurred costs – and some must be paid up front. Many women confused costs of health, but some were clear that they would go to the doctor, understanding it was free, but that it was not useful because they could not afford the recommended plan of care.

6.2 Income Generation

When women spoke about money, they generally spoke about their inability to find work immediately afterwards. Overall, women linked their lack of money to lack of work opportunities. "There is no work, so my mother can't work, so we have no money, so we have no food," one 15-year-old girl said. Most of the women indicated a wish to have micro-financing to do commerce. If not commerce, they wanted factories for women to work in. While they mention some opportunities for employment, the women claimed that "you need relatives [of influence] to find work," or that the work opportunities are for men. However, unemployment is common in men as well. "My Papa picks up orange peels on the streets to sell it at the border [to make perfumes] but it's not enough to survive on," one 15-year-old girl said. Women complained that even if their husbands had trades, such as masonry, carpentry or farming, that they could not find work.

While almost all women spoke about the hardship of finding work, women who were sick lamented that they were too sick to work, and wish they could get better to find work. "Any work is good," one woman said. As well as being a significant piece of most focus groups, the lack of income generating opportunities was also one of the summary findings in many groups. "The problem of Haiti is that there's no work," one woman said to close the focus group.

Generally [unskilled] women's options for income generation in Cap Haitien are commerce, working as a servant in a home or business, and agriculture (much less common in the city). There have been textile factories in the past as well as public works projects that paid women to clean the community, but most of these jobs have been discontinued. While primarily concerned with finding a way to make money, the women also seemed concerned about the respect that comes with their job. Some women indicated that they wouldn't be happy with just any job. "No one respects you when you work as a servant for someone," one woman said. Nurses agreed with this women's perspective that work and income are intimately linked to respect: "When women don't have work, they are dependent, they are not respected and they don't have autonomy." Pressure for income generation is one of the motivations of internal migration in Haiti. Nurses spoke about how people from the countryside were coming into the city to find jobs. Women indicated that one of the causes of unemployment was overpopulation – both by too many children being born, and too many people moving into the city. Many women also spoke about sending their children elsewhere to find work or their husbands leaving to find work – and generally not succeeding.

Even the skilled women found it hard to generate income. Nurses from the Justinian Hospital said that they hadn't been paid for four months. "I'm a nurse, I work, but the work there is not enough to give the means necessary," a nurse said.

While economic activity might start as early (if not earlier) than age 15 for 16% of the population, it is interesting to note that the economic activity (work for money or goods) of women in Haiti across age groups never exceeds 68%[2]. Of women who do work, 47% of them do not work for money, while 51% work for monetary gain. Present or past union with a man is one of the most important indicators of female wealth. Only 7.7% of women who've never had a partner own goods, while 54% of women actively living with their partner own goods. While 38% of unmarried women have money they control, 63% of women actively living with their partner have money they control [3]. In the north, the women have more ownership, with 32% owning a house either alone or with a partner, compared to 26% nationwide [2].

6.2.1 Income and health

Some women spoke of jobs as a preventive measure to better health. They said that if they had jobs they could afford to buy clean water, better foods and go to the doctor. But more specifically, some women connected having a job with mental health issues. "When a woman doesn't work, she spends all her time reflecting, it can influence her health," one woman said. Nurses spoke about how, even if women did not find work, they were always working, whether it is trying to do commerce, finding work, taking care of the house and children, or her parents and other family members. "There is no leisure, women are never able to relax," one nurse said, concerned about the stress women face.

Another strong connection both community women and providers made between income generation and health was the issue of sex trade and STIs. Women spoke about how other women, in desperation would take one man, then another and have sex or a relationship with them for the provision of basic needs. These men are often promiscuous according to women and providers and bring diseases home. "When a woman has all these problems, she tries to solve them. She'll throw herself into a sexual life. The person who gives her money will not wear a condom because it's him that pays for the house," a nurse explained. According to both women and providers, women only succumb to this life as a desperate means to provide for their families and therefore the lack of income generation has a direct effect on their reproductive health.

6.3 Income Disparity

There is no income disparity statistical information available for Haiti according to the Human Development Index. Information gathered from providers and women, however, does show that there is at least an understood disparity.

> "Haitians need to put fire to the apartheid in this country. There are the poor and the rich – those who have everything and those who have nothing. There are two education systems, two lives, two housing systems. My children speak English, Spanish, French, and the others – they speak Creole. There are two speeds in Haiti. Until this apartheid is stopped – until the Haitians and internationals recognize it – there will be no community. It's not a people, it's not a country – it's a bunch of individuals, most who want to leave the country. With this, we cannot hold together. This country will die from internal problems."
>
> - provider, doctor

The team members who conducted the interviews were all upper or middle class Haitians, and all were caught off guard by the poverty they encountered in the communities. Each had had expectations of the poverty in their community, but none were prepared for the level of misery that women described in the interviews. And only one interview team member expressed a desire to stay in the country, while some others wanted to leave, and the rest seemed ambivalent. This income disparity inevitably comes with an education disparity, with the poorer generally being in school for a shorter duration than women with means. This education disparity then fuels the "brain drain" as those educated seek jobs elsewhere to have better and more consistent pay. "The educated all want to leave," one provider said. "Those who are educated do not want just any job that they could find here," said one woman in a focus group. "Those who have don't help those who have not," one woman said in a focus group when speaking about differences between the classes in Haiti.

This disparity could explain why while providers focused on topics of power and agency, the women generally focused on basic needs and symptomatic problems. While the women seemed to be basing many of their needs on the first level of human security – that of basic household needs, the providers prioritize the second and third levels of human security – community networks and health. This indicates that providers often have the first level needs of human security fulfilled while the women do not.

6.4 Schooling

Women in every focus group spoke about their inability to send their children to school. "When I went to school it was 20 gourde for the year, now it is 1000 gourde for the year and I have 5 children. Imagine, 5 children. That is 5000 gourdes! I can't do it," one woman said. Along with the increase in price, women also said that the quality of schooling had decreased. "After the schools of the priests and sisters, the rest are a waste," one woman said. The other women in the group nodded and chimed in expressing that the public school system was not good but that they couldn't afford the private Catholic schools. While women spoke a lot about educating their children, no woman above the age of 18, indicated that their own lack of schooling was a problem. However, no woman interviewed above the age of 50 (about 50 of the women interviewed) could write their name, and no woman interviewed over the age of 54 had ever been to school.

However, providers showed concern that women need to be educated. One nurse spoke about how there are almost no choices for work, but the women must be educated to find work. Doctors showed frustration that women did not understand their own bodies or health. "Even mothers, when they come and I talk to them about their daughter's periods starting, I tell the mother to speak with them, but they say no, they can't do it, they are scared, they do not understand their own bodies and so the girls and the mothers are scared," a female doctor said.

Women did not link schooling with the ability to work or make money. "We finished our studies and cannot find work," one younger woman said. Some older women complained that they had sent their children to school and that even after finishing school their children could not find work. And those who are highly educated attempt to leave. "The most educated Haitians leave, only those who have no information, no education will stay," one female doctor said. While most providers say that the education is getting better, the opportunities for jobs are not.

The focus groups of girls ages 15-20 prioritized schooling, saying "we are sent home because we cannot pay" or that they cannot afford the supplies (books, pens, uniforms) required to attend school. More specifically, the *restavek* group interviewed (none of whom had gone to formal schooling) spoke about how they'd wanted to learn to write their names but couldn't learn until they were 14 or 16. This frustration could have been because they work in homes where the families are of higher income and the children probably go to school.

Some mothers expressed concerns about their daughter's vulnerability to sexual exploitation in schools. "Teachers sleep with them to give them better grades," one woman said about the problems of young women in school.

Haiti has the lowest levels of literacy and education in the Western Hemisphere. Within the population of Haiti, there is a great deal of disparity in the educational status between different groups. Women are as likely to have an education as men across almost all age groups, with overall 29% of women in Haiti having no education whatsoever. The poorer and the rural women are less likely to be educated than the richer and urban women [2]. Overall enrollment is increasing. Education (especially completion of secondary school) is important to health as it is correlated with higher autonomy, safer sexual activity, better economic prospects, better health education, and delayed fertility that can help determine needs of family planning [7]. Women are less likely to complete all levels of schooling than men [2]. Married women 15-19 years old are less likely to go to school than unmarried women, whether or not they have children [1].

Women's education trends in the Northern department of Haiti differs from the rest of Haiti in that more women have completed primary school (47% compared to 43%), and less women have had no schooling (34% in Northern department, 39% in all of Haiti). There is a drop in the completion rate of secondary school or more for women (19% in Northern Haiti versus 28% in all of Haiti) [2].

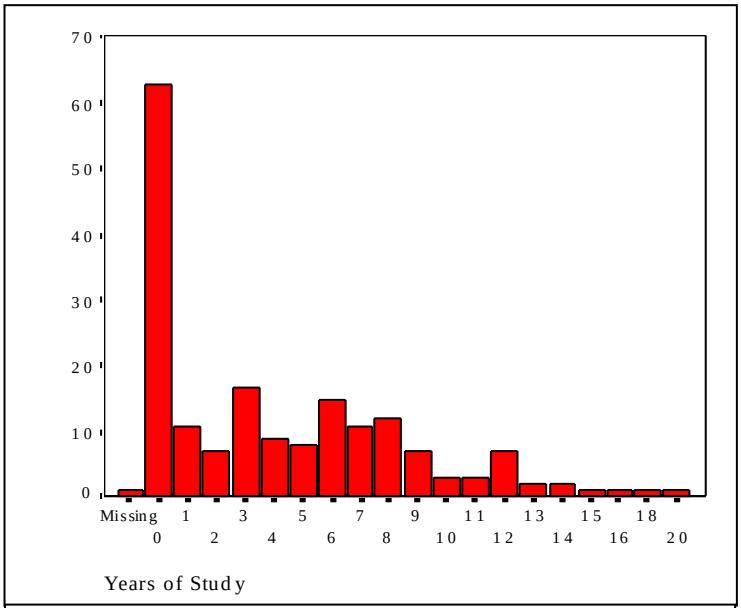

Figure 1: Amount of years in school (n=183).

In the unrepresentative sample of 183 marginalized women interviewed, similar statistics were found. Women who have reached higher levels of education have less pregnancies ($p<0.001$). Women who were older are less educated ($p<0.001$). None of the women interviewed over 55 years of age could sign their name or read. Overall amount of time spent in school was low (Figure 1).

6.4.1 Health and education

Currently, there is health education for children in secondary school (high school). This was evident in one group interviewed (15-20 year old girls from a high school) where they listed diseases and prevention methods just as they were taught in school. However a basic understanding of their bodies was not evident, as most young women did not demonstrate an understanding of their menstrual cycles, their reproductive anatomy or function (i.e.: most women do not know that wetness in the vagina is normal), nor the birthing process (one woman claimed that infants were born with the umbilical cord attached to their heads).

Only 19% of women complete secondary school indicating that health education might need to be implemented in primary school to reach the larger population. Women complained that there is no education on family planning, while providers said that there are many services for family planning that are free of charge, and that if a woman wanted to find information, it is easily accessible. "Sexual education is taboo … girls are afraid of their own bodies," one doctor said.

One woman said, "there are three categories of youth: some who are informed on how to prevent pregnancy and use methods, those who are not informed at all, and those who are informed but don't practice methods anyhow because they don't have the means." While some women could identify centers that could provide reproductive health information, such as La Fossette, Volontaire Development Haitien, other 'clubs' (FOSREF) and the hospital, most women said they did not go to find information. It seems then that making information available in those settings does not necessarily increase the knowledge of the women in the community. Actually traveling and coming into the centers that provide the information might be a barrier because of cost of travel, stigma related to coming, either from their partner or society, and their nervousness about coming into a center they do not know and might not feel comfortable in.

Providers identified the lack of education as playing a large role in the inability of women to follow through with care. "Sometimes we do education [with the patient], it's easy to do, we put all the problems out there, but women will still think of the wrong causes [of disease], they need to be educated," one nurse said. Another provider, a male physician, said that the differences in education between the provider and the women created a communication barrier. "We are trained to speak French medical terms, they only understand Creole, and sometimes doctors really forget how to relate the medical terms in Creole, but the patient just nods their head, they will not say that they don't understand," the doctor said.

Nurses at the Justinian Hospital centered their recommendations on education. "Once I did was in a public health campaign, it shocked me to see what the girls asked," one nurse said, apparently shocked at how little women knew about their own health and bodies. "Even if they don't have work, if they have education, they can be resourceful … they can know what to do … it will help them make decisions on how to live," the nurses said. The nurses were also the most concerned about younger women, to educate them earlier, support them, and give them a place where they can go if they need help. They encouraged using all types of media for education. "Talk, use the radio, scouts, church, school, use the TV to make the messages heard," one nurse said. "Do publicity campaigns; motivate the youth, because if there was education, there wouldn't be these problems. For example, the emergency family planning [the morning after pill], we hide it, we don't talk about it, and the poor young people, they don't know," another nurse added. The nurses were even more frustrated that they couldn't use their education to educate. "Sometimes they send us to seminars concerning education, but afterwards, they don't give us the opportunity to replicate the seminars for others, so we stay here and do nothing," one nurse said. During another focus group at Fort St.

Michel, nurses indicated that they believed that women really wanted to learn. "When they come to the health center, we have information for them. Sometimes, they memorize the information so well that they can site examples for us and repeat the information later on," one nurse said.

Moreover, providers spoke about the need for women to be "prise en charge." This term integrates education, support, integration, advocacy, activism, and solidarity. The closest English translation would be empowerment.

6.5 Gender Power Disparity

> "Women are economically weak. Only the men can find work. So women are not free. This situation creates a family hierarchy; the man or the father is the boss because he earns the money and the woman is living like a servant. The woman needs to be free and learn to live like a human being. She needs to have a stable family. She needs to be able to earn money to take care of the family and make her own decisions. In this society, a woman, even if the man is cheating on her, cannot decide to leave because she won't have money for herself and her children, so they accept to live in polygamy. She cannot leave him. And because of this, let's speak about the affects on their health …"
>
> - female provider, doctor

Gender disparity was one topic where providers and women were the most concordant in terms of how they prioritized it (both mentioning gender often and connected to health, income, education and control). However, while providers framed their arguments in terms of control and power, "women must know their rights, must be able to control their own health," women framed their gender issues in terms of what they were limited in by either not being able to find jobs because men were preferred or because men would not let them access healthcare. Both groups spoke about women's health consequences of battery and forced sex. Women said men's battery caused miscarriages and bleeding whereas health providers were more concerned about the mental health issues and the lack of autonomy women have.

6.5.1 Gender and income generation

Globally, women earn on average 56% the amount that men earn according to the Human Development Index [4]. The women interviewed said that the only jobs available were for men and that they were less qualified than men. While some women actually felt that they were less qualified, other women said that they were not acknowledged by society and that they were discriminated against.

6.5.2 Domestic violence

Women did not speak directly of being domestically abused in the focus groups. However, a few women indicated in the demographic form having been abused. One woman said, "I can't sleep at night, I have nightmares of my husband doing satanic things to me, now he's dead, but I still can't forget what he did to me," when asked about her last time being sick. Otherwise, women brought up domestic violence indirectly. Women mentioned (about other women, or in general) men denying women's needs, women having no choice, women being disrespected, followed, harassed, raped, and hit by men. They also spoke of children being abused by men as well.

In a study based on the Haiti DHS survey, A. Gage found that all forms of violence (physical, emotional and sexual) in Haiti were correlated with lack of completion of primary school, history of violence, partner jealousy, partner control, partner alcoholism, and female financial decision-making. Neighborhood poverty, unemployment, number of children, men financial decision-making, and women's acceptance were additional risk factors for sexual violence. Women's economic independence and relationship quality were protective factors to all forms of domestic violence [5].

Estimates of domestic violence vary among sources. A study done by Yale found that in a group of pregnant women attending Albert Schweitzer hospital in Haiti, 42% of women were verbally abused, 36% forced to have sex, and 9% were punched, kicked or slapped (during their pregnancy). These women were exclusively victims of violence from their partner [6]. Gage's study (based off of DHS) found that 29% of women surveyed experienced partner violence in the 12 months preceding the survey date, 13% having experienced at least two different forms of violence [5]. These differences can be partially explained by the person committing the domestic violence. In Haiti, 44% of domestic violence is committed by someone other than the woman's partner, while 28% is committed only by their partner, 11% by an ex-partner, and 17% by their partner and others [3].

A study of women's attitudes about sex has found that women feel that satisfying the needs of their partner is the most important reason to have sex, while their own enjoyment was identified as the least important reason [6].

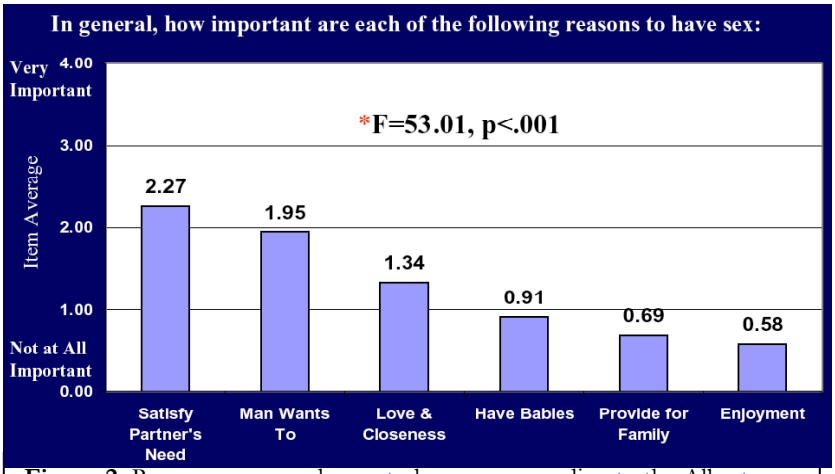

Figure 2: Reasons women choose to have sex according to the Albert Schweitzer Hospital Study in rural Haiti with pregnant women seeking prenatal care [6].

In Yale's study, women generally claimed that they could say no to sex. Only 8.7% of women claimed they could not deny sex to their partners. The most agreed with justifications for denying sex were knowledge of an STI (87.5%), just having had an infant (84.8%), knowledge of partner cheating (77.2%), and being tired/not in the mood (73.6%). While women seem to understand their ability to say no (64.3% agreed with all justifications for denying sex), it seems to seldom happen, and the amount of forced sex is very high (shown later in the section about domestic violence) [3]. "In couples, the man is in control. The woman cannot even make sexual decisions. They can't express their desire for sex. There are women who never have orgasms and have no right to express her desire. So they live in a house where they are not satisfied sexually or emotionally, where she must accept infidelity …" one doctor said.

Women spoke about domestic violence in a non-personal context, except in some personal demographic interviews where a few spoke about being personally beaten. No woman spoke about rape personally. In almost all focus groups however, women brought up fear of rape or rape as a common occurrence in their communities. Both rape and battery were always brought up with anger, fear or sadness. Providers were often frustrated and saddened by the apathy they viewed women to have concerning battery and rape. "They accept it because they may not have other options. It's just one more thing in their misery – they are miserable anyway," one doctor said. One female doctor claimed that women even saw battery as a sign of love, that women not only accept it, but expect it and feel neglected if they don't receive it. Other providers were frustrated at the acceptance of mistreatment. Even when resources and recourse are available, providers who work with women's advocacy said that women did not take action and would remain complacent.

Many providers also voiced concern that the hospital did not give women adequate privacy for these issues. "We examine them and everyone sees," one provider said. "We do not talk to them about who the aggressor was, especially if it is the husband and he is present," another doctor said. No

women had ideas of where they could go, nor did they prioritize gender issues when asked to enumerate their priorities out of the issues they had brought up. While women brought up and spoke about gender issues continually, whenever asked to number issues in lists of priorities, gender issues would be left to the end. Some women explicitly shared experiences about being beaten or mistreated at home. But the women seemed to indicate that gender discrimination in their society was a more important issue that gender issues in the home. They spoke about unequal job opportunities and being considered inferior to men in their society. The providers viewed gender issues differently – they were one of the providers' key priorities in increasing both the health and access to healthcare of women. "You ask a woman when her last menstruation is, and she'll ask her husband," one doctor said frustrated. Providers spoke about how men were prioritized over women in the home in the access of schooling, food and control. "In my family, things weren't this way, both boys and girls went to school and were treated equally," a doctor said, "but for these women, it is very different, it is our culture."

Domestic violence is not exclusive to the man and woman of the house. Both women and providers spoke about violence toward children. Some of the younger women (15-20) mentioned child beating and one 48-year-old woman spoke about abuse from her stepfather. When speaking about being beaten, women would use ambiguous language, such as "he did bad things to me" or "I had bad experiences with him." Parent (or step-parent) to child abuse was only mentioned as male specific, and it was generally stepfathers or men of households women worked in that were mentioned.

6.5.3 Gender roles at home

> "The man plays a very important role in Haitian society. The man occupies almost all the important positions. In the family the man is considered like a god, he can do what he wants to his wife. If the woman refuses, the husband won't give her food for the house as punishment."
>
> -a 50-year-old woman

Gender roles are fairly rigid in Cap Haitien. One provider, a female physician, talked about how it is not accepted for women to live alone, they either live with their families or with a man and their children – and often they end up with only their children. Many women spoke about women being abandoned by men. Young girls (15-20), when asked what the problems for women of reproductive age were, responded "fathers deny paternity." Both providers and women repeatedly spoke about the woman being the sole caretaker of the household. "At the house it's the women who carry all the problems," one woman said. Many young girls said they didn't have fathers, either because of abandonment or death, and that the mother took over the role of father – that the mother takes care of everything. The issue of partner abandonment was brought up in each focus group, sometimes more angrily or accusatory than others. One woman said, "You can have a man who adores you, when you are not pregnant, but when you get pregnant, or ask for money, he leaves you," and another woman responded, "Men send you to hell." Women identified family as the only safety net: "If you don't have a good family, there's no place to turn."

In about half the focus groups women spoke about dead husbands. This might be affected by the lower life expectancy of men (50 versus 55 for women). While women spoke about the negative effects men had on their lives, they would repeatedly talk about needing a man or missing a man in their lives. There were however, during the demographic interviews and a couple of focus groups, women who spoke about being happy to be without a man, either because their prior husband had physically, sexually, or emotionally abused them.

Providers and women alike spoke of the higher status an older woman had. Grandmothers are looked to for wisdom and support. The older women interviewed said that while they couldn't find

help, at least they are listened to. Older married women are significantly less likely to experience domestic violence than women aged 15-19 [1].

The EMMUS III study surveyed women on what was discussed in the home. In serious decisions and household decisions women reported having some power (39% of women had more power in serious decisions, and 35% of women had more power in household decisions). In discussing decisions, the most commonly discussed items in the household are how to spend money (57%), household happenings (55%) and what happens at work (48%). Thirty-four percent of women claimed that they did not discuss any important areas of interest (money, home, work or community) with their partner. These women all currently live with their partner.

6.5.4 Women's sexual choices

Women also spoke about "women who steal another woman's husband" as a problem for women. They did not explicitly link the need for men with money, but women did mention that women would sleep with men because they didn't have money, or would take a man, after being abandoned, to be able to pay for their needs. They would also indicate that all the jobs available were for men and that women could not find jobs. This inequity creates a dependency of women on men for income. "Women have no choice but to live a sexual life, they can get HIV," said one woman, to which another responded, "It's not the woman's fault, she did not choose this." During one focus group, women indicated this exchange of sex for goods or income as a viable option but speak about the negative repercussions of it: "we can do this, but it can get us pregnant which just causes more problems" or "the man will help but will give her more children and then abandon her, and then the woman must find another man who will help provide but then give her more children again and again abandon her." One provider likened the dependency of women on men and their trading sex for provision of basic needs to a system of prostitution. "Men beat them, they're poor, they're uneducated, they have too many children too fast with too many different men, they get into a cycle where they will accept a man to get money or get something. It's not real prostitution, the way we know it, it's not an institution, it's to survive," she said.

As dependent as they might be on men, women do not tend to seek their advice, according to providers. "They don't seek the advice of the man – they just want them to take them to the doctor. The men come, and they have no idea what is going on. "I saw her abnormal," they say. There's no asking of advice, no communication," one doctor said.

Echoing women's worries, studies show that in Haiti, women's financial stability and wellbeing are often connected with their choice in partner. Within relationships, women seem to sacrifice decision-making power for the benefits of stability. EMMUS III surveyed the decision making power dynamic, asking women what they had decision-making power in. They found that while women living with their partner had only 48.7% power to decide to use contraception, they had much stronger decision making power in what went on in the home (food and money), their work, and their health than women without partners[3].

6.5.5 Polygyny and health

Outside of Sub-Saharan Africa, polygamy (on the part of the man) is found in few countries, including Haiti [1]. However, while official polygamy seems to be decreasing, it has been replaced by monogamously married men who form informal unions with one or more other women[1]. Providers were especially concerned with the effects of polygamy from men on the health of the women. According to EMMUS III, very few women report multiple partners or promiscuity on their own part [3]. While they may take a man for security or in desperate situations to gain access to basic needs, they don't report multiple partners, which may be due to their alternative partners being

generally consistent. Both focus groups and providers indicated that women bartered sex. Providers prioritized the health affects of this promiscuity, namely increasing risk for STDs and decreasing family stability and women's autonomy.

6.5.6 Societal Discrimination

In one interview, a woman said, "When we go to the hospital to seek care for a wrong we have suffered, the miss [nurses] don't help you, and it's at this moment that they tell you their story." Women providers, as well as the poor women suffer from the gender inequality in Cap Haitien. All of the nurses in the focus groups were women. "We are women. We have the same problems. We are treated as insects. We are almost invisible. Sometimes the doctor will not see us either," one said.

Female doctors and women's advocates spoke about women's limitations in participating in politics. "Women cannot get jobs and cannot be in politics. They think a woman cannot be trusted. That is why we have a lot of educated women who don't – who should be – but do not get involved. It is because of discrimination against women. Women have no jobs, no power, no rights, no facility to go into politics, no freedom," one female doctor said. According to some providers, women, even if they had resources, could not live alone, could not find jobs without connections, could not leave their husbands, and could not use bank accounts without the consent of a man. There is, however, some hope as women begin to organize. "A lot of women think that men cannot run Haiti anymore," a male doctor said, laughing. "We're seeing more and more of women organizing. It's acceptable now," another doctor said. But men have not joined in the struggle for women's rights. Providers are hopeful, however, saying that this is just the beginning. However, some providers believe that this effort has not reached the poorest of the women and that it will take a long time.

6.5.7 What is the role of men in women's health?

This question was added to the focus group questionnaire after the first two focus groups were conducted and it was realized that women would speak about it openly and might give more information if directly asked. Some common answers were "men give women HIV," "men are unfaithful," "they make you pregnant and leave," "they make you abort," "they beat you," "they don't let you go to the hospital," and "they take one woman then another." While some answers varied, none of the respondents identified a positive role for men. While women also discussed infidelity in responding to what their general problems were (question 1 of the focus groups), it was never a priority. However, it was a priority in their responses to the role of men in their health. Some said that they should use condoms if the man is unfaithful at which other women scoffed.

Some women indicated that they could not speak of their problems in the presence of men. "Only between women can we say these things," one woman said at a focus group done at Fort St. Michel. Other women said that they could only share their problems with their women's groups at church, but even then, most of the time no one cared or asked about their problems.

Providers were very concerned with the limitations men created when it comes to providing women with healthcare. Providers brought up almost all the same issues as the women – battery, forced abortion, men's position of control of money and therefore most life aspects of the woman, such as not letting the woman seek care or take contraception. Nurses at Fort St. Michel indicated that a woman's health is closely connected with men's health. "Men must be in good health for the women to feel well," one nurse said. Some nurses, however, said that if the men were "encadre" – meaning educated and well supported and mentored, that men can treat women very well physically and materially.

Specific to STIs and reproductive health issues, doctors and nurses said that women would not speak about it in front of the husband, would not implicate the husband and would often be afraid, or just refuse, to tell their partner if they had an STI due to fear that the male partner would leave. Providers also indicated that men often refuse to be treated and that they sometimes don't believe test results.

However bad a man's role might be to the women, the women who did not have husbands lamented that they had no husband to depend on. "I don't have a husband, he's been dead for a long time, it's only God I have," one woman said.

6.6 Religion and Traditional Medicine

The two subjects discussed in this section are much intertwined. Religion and traditional medicine have developed together, both through Voodoo and Christianity. Whereas many of the traditional health providers use spiritual remedies that are intertwined with Voodoo, many women who do not go to traditional healers have substituted the modern church – Christianity. They either pray to be healed, have prayer groups of healing or go to their priests for healing. Their spiritual beliefs and their beliefs about traditional medicine are intertwined.

6.6.1 Religion

Each time a focus group was asked either who they go to for health information or health provision, or who they trust, the answer was always in some form, God. One young girl, when asked where she went for healthcare said, "We ask God for forgiveness because we have sinned." Both women and providers indicated that women often linked sinning to being ill and that many women would seek spiritual healthcare because of this belief. "I pray and I feel better," one woman said.

Many see religion as their only recourse. When asked where to go for help one woman said, "I accept Jesus because I don't have parents, I have no one in another country that can help me, only Jesus." Many women see prayer as a healing power, though some women complain that it doesn't work: "The blind man in the Bible, he asked Jesus to let him see, but us, we need to see, and then [nothing] (she shakes her head and looks down)." A matrone spoke about the limitations of God being able to heal them, "After God, it's money that lets us live." Along with prayer, women spoke of fasting as a way to both regain good health and prevent bad health. Fasting, more than a chosen period of not eating, is a time of meditation and celebration. "They pray, sing, celebrate, I'm sure they don't eat, but they generally don't eat anyway," an NGO representative said.

Many providers were concerned with religious as a barrier to healthcare. Some nurses spoke about how women wasted precious time seeking healthcare through their church and prayer when they need emergency care. "They believe they can't go anywhere, so they pray. This is a population that prays a lot," one nurse said. Another conflict between religion and healthcare is that some churches in Haiti are against family planning which all providers, save one, were proponents of.

6.6.2 Traditional Medicine

All of the providers indicated that traditional medicinal practitioners were the first health provider to be consulted. "They often think sickness is a curse, they don't see the biology of it," a nurse said, explaining the reason women used traditional methods first. A third doctor voiced concern about women seeking traditional healers: "The traditional remedies are a waste of their time, money, and it delays them getting care." Generally providers of occidental medicine spoke negatively of traditional methods and claimed that almost all women sought traditional methods first. Interestingly, however, one doctor said, "even if us doctors don't believe in them – if nothing works, we sometimes seek traditional methods as well." Some nurses indicated that traditional healers can be helpful. "When

they get sick, they think that it's not biological, they go to traditional healers who encourage them to come to the health center," one nurse said. Some women's health histories concurred, with stories of them going to traditional healers, trying a few methods, and when they continued to be sick, the traditional healers recommend that they go to the hospital for care.

As part of the demographic form, women gave their last health history. Almost every woman said that she had tried teas, baths or body rubs before she went to the hospital – if she went at all. If not, the woman indicated that she'd try traditional methods if medicine didn't work. Few spoke about going to see traditional healers. Many women stipulated that they would rather go to the hospital or a clinic than use traditional methods but that they cannot afford to.

Some women mentioned books on teas and one even recommended creating groups that teach herbal remedies which they see as the basis of their traditional medicine. Another aspect of traditional medicine that women and providers spoke of was the ability of the traditional healer to "use both hands," meaning that the traditional healer used both physical remedies as well as spiritual remedies. However, the some women indicated that the physical remedies, such as skin rubs and baths were unpleasant and that they'd prefer, if they had the means, to use modern methods.

6.6.2.1 Why go to a traditional healer?

Both the key informant and women's questionnaires asked why one would go to a traditional healer. Women generally said they used traditional methods for common symptoms and signs of illness, such as a fever or cough, claiming that if it were serious they would try to seek formal healthcare. Providers spoke of diseases that women saw as curses – mental illnesses, epilepsy, chronic illnesses and terminal illness. "When they're taken to the countryside to seek the traditional healers is when they're really sick. If they go someplace with someone who is really sick and it doesn't work, they wont tell that person, they'll just go somewhere else. The patient will not know what's going on in their healthcare, it's maybe to protect them, but there's no consent," one nurse said.

6.7 Social Networks

In a society with low financial capital, social capital often is of utmost importance. The social capital in Cap Haitien consists of the support networks the women have, including their families who they trust and who financially and emotionally support them, and the city community.

6.7.1 Disintegration of families

As mentioned previously in the housing section of the chapter on basic needs – many children do not live with their parents. Their families are broken up into other houses of relatives or friends. "I tried to put my child in an orphanage, but they wouldn't take him, so I gave him to a friend," a woman said. In urban areas outside of PauP about 6.1% of children are living as *restaveks* [2]. Or the opposite may happen, a woman houses children that are not her own. "I have 5 children who live with me, three are not mine. The mother left them with me because she couldn't pay," one woman said. It is reported that 28.6% of children living in urban areas (excluding PauP) live without their parents [2]. There are many reasons women reported the need to either give away or accept children. The general reasons were either lack of income, death of the mother and child abandonment. This disintegration of families based on their inability to access basic needs leaves a heavy burden of guilt on some women. The elder women, who are looked upon for support and wisdom according to both women and providers, spoke about feeling useless and being unable to fulfill their responsibilities.

One of the ramifications of family and community breakdown is the discontinuation of information flow – especially health information. Many women stated that their homes was where they learned

basic issues of health and prevention – specifically from their mothers – therefore, if children are being given away or dispersed; the traditional routes of teaching are broken. One nurse said "children live without their parents, with little kids, psychologically there's no one for them to trust."

Young women (ages 15-20) were the most concerned with the breaking up of families. When asked about the most important problems of women in Haiti, they prioritized "abandoned children" growing up without their fathers, without their mothers, and without either. A group of *restaveks* interviewed were the most open about domestic violence in the home, speaking about men beating their wives, children being mistreated and hit with shoes, chairs, spoons, or belts. The *restavek* group also spoke about being beaten themselves by the families they were given away to.

There has been an effort on the part of UNICEF to stem the giving away of children in Haiti. One of the nurses in the nurse's focus group at the Justinian Hospital displayed anger at UNICEF. "There are some women who refuse to give their children to domestic service. It's the fault of UNICEF. UNICEF is against the children being given away in domestic life, it tells the women not to give their children away, but it doesn't do anything to take care of these children," she said. The nurses said that there were benefits and problems associated with the system of children being given to do service. "There are some people who really mistreat these children, but not everyone," one nurse said. Another responded, "It's an exchange, the child works in the house, and the people take care of the child."

When asked what had changed in their lifetimes, many women spoke about the decreasing ability to acquire basic needs for their family. "Before the parents could help their children, but now parents don't have the means to help their children anymore," one woman said. "We must send our children away," another said. Sending their children away does ensure success however, as many women said that their children had either gone to the Dominican Republic or PauP and either had to come back, empty handed, had lost contact altogether, or that they were stuck where they'd gone to and could not come back because they did not have the means to do so. "They kill the youth who go to study in Santa Domingo," one woman said.

When parents cannot provide for their children, there is often a disintegration of the parent-child relationship [8]. Women echoed this finding in their complaints that children no longer respect their parents, they do not listen to their parents and that they keep secrets from their parents. "If girls get abortions, they don't tell their parents, they don't go to the hospital, so they can't get help," one woman said. This lack of respect is echoed by adult women and their elderly mothers. While elderly are generally respected, some women indicated that their mothers were of no help to them, and that they had to support both their children and their parents.

6.7.2 Disintegration of communities

As the second element of human security – the community needs are threatened by this disintegration. While indicating in detail the problems within the family, many women also spoke of the lack of solidarity within their communities. They said there was no help, no one to go to, no one cared and that there was no unity among women or within the community.

Poverty and the need to find income generating opportunities create a pressure for internal migration in Haiti. Providers spoke about people from the countryside coming into the city to find jobs and women indicated that one of the causes of unemployment was overpopulation – both by too many children being born, and too many people moving into the city. Many women spoke about sending their children elsewhere to find work or their husbands leaving to find work – and generally

not succeeding. In one focus group, when the women were asked where they were raised, one-third of the women answered that they had moved to Cap Haitien as adolescents or adults.

There is also a lack of integration in the healthcare community. Nurses and physicians alike spoke about the lack of collaboration of hospital staff. Nurses complained that they weren't respected, that the interns would not collaborate and that the doctors would not listen to them, even if they'd been following a patient. Providers spoke about absenteeism and the lack of cohesion and dedication providers had to their jobs.

Insecurity exacerbates the disintegration of the community of Cap Haitien. Women spoke about how the lack of security and the increased violence worsened the lack of solidarity in Cap Haitien. This directly affects healthcare because taxi drivers will refuse to drive into the city or even providers will not come into the hospital if the security situation is bad.

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VII. Health: Problems and Perceptions

As evidenced by the other chapters, this health needs assessment was very broad. In order to understand how women prioritized health, and what they perceived as health, they were asked their general problems and their understanding of health, as a whole, and afterwards their perceptions about specific conditions and diseases as they were mentioned in the focus groups. Key informant interviewees were asked specific health questions based on their expertise and the perceptions women explained in the focus groups.

10.1 Summary Results

Overall women focused on their personal health problems (themselves, their children and their family), symptoms and physical limitations, and a few specific health problems that they could name. Health perceptions differed depending on the age group of the women, the younger women (15-34) knowing more preventive measures, more health access points, and being able to explain some common diseases and conditions and their method of transmission.

When asked in general what problems women had, health was mentioned in about half the focus groups. Some women indicated unspecific issues such as health or hospital, while others spoke about specific health issues such as respiratory problems ("we breathe in trash"), injuries (both from domestic and societal violence) and HIV/AIDS. Women prioritized symptoms (fever, headaches, dizziness, weakness, soreness, 'thin blood' [anemia], 'sugar' [diabetes], 'low uterus'), some diseases by name (TB, HIV, anemia, sickle cell anemia, malaria, typhoid) and some nutritional issues (general malnutrition and kwashiokor). Questions about health included what the most important health issues are, what health priorities are for different age groups, and assessing the perceptions of different medical conditions raised by the women.

It is important to note that even when asked specifically about health, many women referred to basic needs, socioeconomic issues or public services – generally used as causes of health problems. When asked what the health issues are for younger women, most answers revolved around cultural and socioeconomic issues, such as needing to find a man for money or having sex too young. Some women (especially the younger women) gave specific reproductive health examples such as eclampsia, pregnancy, hemorrhage and HIV/AIDS, but most spoke about men (gender issues), supporting their children, sex bartering and lack of jobs. For older women's health issues (55 and over), most responses to the health questions included personal stories of illnesses of them or their families in great detail.

The priorities women listed regarding health problems included infections, too many children, HIV/AIDS, and not being able to afford medical care. The most important problems young women experience, according to the women in the focus groups, were: abortion, vaginal infectious, promiscuity ("sexual pleasure", "contact with too many men", "sexiness", "taking others husbands", "sex for food and clothes", and "sex too early"), cramps, anemia, and some specific diseases such as HIV/AIDS, tuberculosis, and syphilis. Many of the health issues mentioned that related to young women were accompanied by mention of economic issues. Women claimed that it was lack of income and opportunities that made younger women choose to have sex with men. One woman said "teachers give grades to the young girls who sleep with them."

Women of reproductive age spoke about socioeconomic and reproductive health issues. They mentioned men abandoning women, having too many children, 'low uterus', abortion, eclampsia, infertility, vaginal infectious, and family planning. Other than reproductive health issues, they

mentioned cancer, aging too quickly (due to hardships), and begging. One women said that women who are pregnant have no health problems, because they can get free health care including vaccines, prenatal care – but that many don't go.

The health priorities for older women differed from the two younger age groups in that the responses were focused on chronic illness and physical conditions. The most commonly mentioned hardships were blindness, deafness, hypertension, 'sucre' (diabetes), heart problems, acid reflux, and difficulty in physical movements. One woman (55 and over group) talked about how she could no longer use the latrine because she could not squat. Older women also mentioned problems of sadness, or lack of peace. The youngest groups (15-20) were concerned with the sadness of their elders.

Women in the focus groups severely lacked a biological understanding of their bodies and reproduction. One woman indicated that an infant's umbilical cord was attached to their heads, and older women sometimes referred to 'having no more periods' as a health problem – indicating no understanding of menopause. Another important bodily misunderstanding was the condition of the vagina – almost all focus groups spoke about it being normal to have a 'dry' vagina and repeatedly spoke of having moisture in their intimates indicating a health problem. "They think that any [vaginal] secretions are abnormal. Even if I say they are normal, they ask for antibiotics," said one provider.

A pediatrician explained that many female health issues are treated as taboo, "When I see them in my clinic, I try to inform them, educate them. First I try to talk about their body – they don't understand their physiology or anatomy. I try to talk to them about their menstrual cycle, how it happens, how we can get pregnant. When I encourage their mothers to talk to them, the mothers shake their heads and seem scared, they can't even talk to their own children. It's taboo, and the children don't know who they can talk to – they feel they can't talk to anyone."

10.2 Definition of Health

Women were very comprehensive in their definition of health. Women indicated that health meant having clean water, food, being healthy (not being sick, not having negative symptoms), having good respiration, being able to function, and being able to work. They also mentioned being able to see a doctor regularly, having access to medications prescribed, not having stress, having peace (in home and in country), not having violence and being able to sleep as definitions of health. "To have good health in our thoughts," on woman said. Another echoed with, "for women to be healthy, all those around them need to be healthy." In all, women brought up physical health, mental health, and issues of access and public security as health definitions. Additionally women would speak about how to have good health was to be rich and how to have money would help them to be healthy.

While many women spoke about violence as a problem they had (societal and domestic, all types: physical, sexual, emotional, verbal), generally they did not include this in their health discussions and did not extrapolate on the health implications. Only the younger groups, 15-20 included injuries as a priority health problem, and only the group of restaveks spoke about injuries personally and prioritized beatings as their number one health problem.

10.3 Health Information

Women indicated that they received their health information (about health risks, health access and preventive methods) through primarily their homes and family. The younger groups mentioned schools, the radio (specifically Radio Atlantique), health centers, information seminars (at the MSPP and in communities) medical professionals (doctors and nurses), Church, prayer and God as sources

of health information. The health centers that were specifically mentioned were CDS La Fossette, VDH (Volntaire Developpment Haitien), Milot, Morne Rouge, and Justinian Hospital. The older groups spoke about getting health information from street merchants, family, the radio, neighbors, people they met on the streets, God and nowhere as sources of information. One older woman said, "If we knew where to go, we wouldn't have these problems."

When asked who they trusted first when they had a health problem, many women mentioned the same source as where they get their primary health information – family, or in the home. The most common person women turned to was their mother, followed by grandparents and 'older people', followed by God and Church. Only after family and religion did women say they'd go to a doctor or to the hospital. One older woman said, "I can't afford to go to the hospital, but as an older woman, at least people will listen to my pains." And many older women ended up by saying that truly, they could go nowhere when they had a problem, or at least, nowhere that they could change their situation. Who they spoke to first differed from where they sought healthcare first. Most women claimed that if they could afford medical care they would go directly to the hospital or a clinic, but that since they couldn't, they would often either go to church, fast, pray, go to charlatans or merchants, or often, nowhere.

10.4 Prevention

In terms of prevention, women focused on two types: those for generalized infections, and those for STIs. As stated at the beginning of the chapter, knowledge of preventive methods was highly age-dependent, the oldest groups often saying that they knew no preventive methods – saying even, that infections hadn't existed before, and that they were new. "All we hear now is infections, infections, infections," one woman said, saying that she did not understand them. One older woman said, "if I knew [preventive methods], I wouldn't be sick." However, the younger groups would talk of hygiene, good nutrition, exercise, sanitation, seeing a physician regularly, fidelity and condoms.

Specifically to prevent STIs, women indicated that condoms, hygiene, abstinence and fidelity were ways to combat infection. However, over half the focus groups said that water and temperature were causes of vaginal infectious. "If we bathe in cold water and sit on something hot, we can get sick in our intimates," one woman said. Vaginal infections were sometimes referred to 'gran chale' meaning great heat. It is possible that the women believe that vaginal infections come from heat or cold because of the symptom of heat they feel when they have a vaginal infection. Another said, "do not wash your face and then wash your intimates with the same water, or else you can get a disease." Accordingly, some women spoke about warming water to bathe in, and not sitting on cold surfaces as preventive methods for STIs.

The women's understanding of preventive methods followed their beliefs on where the diseases or ailments came from (as shown above with vaginal infections). Many women (especially in the younger groups) spoke of microbes in the water. "Even if the water is clear, if you put it in a machine, you see it is full of microbes," one woman said. They spoke of diseases being carried by flies and mosquitoes (specifically general fevers, malaria, and typhoid); therefore they spoke about cleaning the house of flies and mosquitoes and keeping food covered so flies would not contaminate it. The women also indicated that dirt and trash were carriers of disease, saying that 'breathing in trash' made them sick and that they should not walk barefoot.

The portion of the focus group that covered prevention was often one of the most animated pieces, where women would voice their ideas and opinions and it generally turned into a small peer-teaching session. With the combined knowledge of most focus groups, there was a fairly accurate picture of hygienic and safe health practices. However, the more educated women, those who were involved in

a health or nutrition program, and the younger women had more knowledge to add to the discussion, and the older women and those who didn't have access to a health program, often had either no information or inaccurate understandings of disease prevention.

10.5 Available Health Services

The two divisions of health services in Haiti are the traditional sector and the occidental sector. Within each of these more subdivisions into specialties and types of health centers. Women's decisions of which healthcare services to access were largely based on either their belief of the origin of the problem, or barriers they perceived to accessing occidental care. Within both health sectors women spoke of both benefits and problems. Overall women tended to choose the cheapest and easiest to access care first, and if problems persisted, they went to the next cheapest and easiest. Many women were hesitant to speak at length of traditional medicine although most of them indicated having used some traditional medicinal method in their demographic interview. Other less mentioned, but important alternatives, women discussed were seeking religious treatment, through fasting, prayer and religious groups, and going to charlatans (medicine merchants in the streets and abortion providers).

Women often mix their choices of healthcare. "I have a child who is 7 who has severe dizziness and weakness. She's very skinny and pale. At the hospital, they gave her syrup, but I don't know why. The child gained weight, but the dizziness persisted. I had a son who wouldn't speak, he would hide all the time, he seemed afraid of people, so I went to the ougan to find a solution, and we found the solution. He told us that the child was bought by Satan, and that we had to sacrifice a goat to Satan so that the child could be cured. It worked. I'm Catholic, and I didn't take communion for a year," one woman said, describing her experience with choosing care for her children.

10.5.1 Traditional Medicine

There were some reasons why women said they would choose to go to the hospital, such as broken bones, severe injury, and the failure of other methods. However, according to both women and providers, traditional methods (either done at home or sought by traditional healer) are both the first and the last methods used. It is important to note that within conversations with women and key informants that there were multiple ways to attain traditional methods such as: at-home traditional remedies, merchants (oils and leaves), traditional healers ("ougan"), and healers that "work with both hands" – indicating that they are trained both in traditional and occidental methods. Older women were more likely to use traditional methods and seek traditional healers. They were the only group who would speak about seeking out an ougan, or would say that traditional methods worked while occidental methods didn't. One said, "I had a fever, I took medicines that didn't do anything, and I drank traditional teas and it worked."

When asked what reasons they might seek traditional medical care, reasons ranged from fever, not having money for occidental medicine, none, and everything. Some women (especially some in religious groups) were adamantly against seeking traditional medical care. However, in the demographic interviews all women had at the very least used some traditional remedy used in the family or community. There were some ailments that women said were only cured by traditional care including severe mental illness, seizures, curses (characterized by incurable symptoms that they have sought care for), and mysterious pains. "My son had two sicknesses, one for the doctor, and one for the ougan," one woman said. Providers added that often with terminal illness, when occidental medicine cannot save the life of the person, family members would often take the patient to the countryside in search for traditional medicine as the last effort. The primary reason for choosing traditional medicine was the cost – traditional medicine was cheaper and traditional healers provide credit according to women. Whereas there is flexibility in the prices of traditional medicine,

occidental medical care has rigid prices. This was one of the few comparisons that women mentioned as showing traditional medicine to be better.

Some women pointed out that traditional remedies were "always the same thing" and that they generally smell badly or tasted badly and that traditional healers were not trained to identify the ailments the way occidental medical practitioners are. One women spoke about having to seek traditional medical care for her two children because she could not afford to go to the hospital, but that her sister, when her children came down with malaria and typhoid, she could afford hospital care and her children healed quicker. This woman cried saying that her children had had to stay sick for weeks because she could not afford hospital care, and was scared that if her children became ill with something that required medicines, that she could not afford it. Another woman indicated that going to a traditional healer worsened the health problem – though she did not indicate how. Providers often spoke about how women delayed occidental medical care by first using traditional methods and that often when finally presented at the hospital, the malady is often worse and the prices often higher because of the delay in care.

Self-applied traditional methods which women used included teas, body rubs, baths, prayers, oils, herbs, etc. Reasons why they would employ traditional methods were "everything" including: fever, stomach problems, headaches, aches, period cramps, venereal discharge, etc. When asked where they learned these methods, women responded that traditional methods used in the home are passed down by family members, or older community members. Many women indicated that they would always follow the advice of their elder family members, even if they would rather go to a doctor.

One specific type of traditional care is used during pregnancy. Many women spoke of baths and teas a woman was to drink around the time of her labor. This care was not spoke of as optional, but compulsory. "Women must bathe in leaves when they give birth," a woman said, while the rest nodded their heads. Along with traditional practices during pregnancy, women often seek out matrones for their delivery care. Matrones are traditional midwives that are generally older women, but in some cases can be young or even men. A study done by Deborah Barnes-Josiah in Haiti showed that between 60-70% of women were attended by traditional birth attendants when in labor and that 67% of women had at least one prenatal care visit from a TBA [1]. We interviewed a matrone as a key informant, but she was so hesitant to answer that it is likely her answers were tailored to fit the interview. She did, however, speak about her desire to be linked to the hospital so that she could refer women and her need for sterile supplies for her practice. She said that matrons generally don't make enough money to buy the supplies necessary to do their job and that they often have to use house rags instead of clean cloths.

One doctor said that in most cases he encourages the use of traditional methods, except when it can be detrimental to the patient. He argues that if he tries to convince patients not to use their methods, that they will not follow his advice, therefore he uses both as complementary. He went on to say that even doctors use traditional methods, either because they are just family tradition, or because they become sick with an illness that does not succumb to occidental medicine. He laughed saying, "traditional medicine is not only for the poor but a whole cultural construct that has become part of the thinking of the Haitian people."

10.5.2 Occidental Medicine

The Haiti health system is broken into 3 systems: the public sector (government run), private sector (either NGO or physician run) and the semi-public sector (government-private partnership). There are a total of 663 health institutions (hospitals, clinics, private health offices, public health offices, etc.) with 49 hospitals and 61 inpatient facilities (as of 1994). One third of all Haitians health

institutions are in the public sector. This sector is the most affected by instability, both by funding and governance. International funding is often given to the semi-public sector through NGOs– with 32% of the hospitals operated by NGOs [2]. Below is a chart of the facilities in Haiti:

Table 1: Health facilities in Haiti [6].

TABLE 1
Breakdown of health care facilities, by category and sector, June 1994.

		Category					Sector			
Department	Hospitals	Inpatient facilities	Outpatient facilities	Clinics	Asylums	Total	Public	Private	Mixed	Not specified
Artibonite	4	11	16	52	1	84	37	26	20	1
Centralga	2	1	10	31	0	44	20	15	7	2
Norde-Anse	2	9	5	41	3	60	28	6	26	
North	1	10	10	30	1	52	19	10	23	
Northeast	1	4	1	16	0	22	10	3	9	
Northwest	1	7	4	46	1	59	18	16	25	
West	33	9	82	109	2	235	54	127	54	
South	4	8	7	51	1	71	25	4	42	
Southeast	1	2	4	29	0	36	23	9	3	1
Total	49	61	139	405	9	663	234	216	209	4

Source: PAHO/WHO, list of facilities by geographic area.

In Cap Haitien, occidental medical facilities include dispensaries, public clinics (Fort St. Michel), private clinics (CDS La Fossette), the public hospital (Justinian University Hospital), and the private hospitals (i.e.: Milot and Pignon). Just as the women would use different traditional methods depending on the problem and their resources, the same is true for their use of occidental medicine. Many women, especially when pregnant would go to private clinics such as CDS La Fossette and then deliver at home or at the hospital if they had complications. They would often prefer to go to dispensaries first to seek medicine as a cheaper and quicker alternative to first seeking clinical care. Women preferred the private clinics and hospitals to the public ones because of perceived better services, better environment of care, cheaper prices and shorter waits.

Reasons to seek occidental medical care

The first response to why they sought medical care was injury. Next they mentioned reproductive medical emergencies. Only after naming different types of accidents and medical emergencies did women speak of general infections and symptoms that they would seek occidental medical care to heal. However, many women indicated that really, they should seek occidental medical care for everything, but that they didn't have the means; therefore they had a hierarchy of needs that informed their decision of whether or not they should seek occidental healthcare. Women's reasons for why occidental medicine was better included that doctors are trained, doctors use tests and analyses, occidental medicine uses tools (machines – like x-rays), and that the medications used in occidental medical care are specific to the health problem.

Barriers to seeking occidental medical care

When asked what barriers they faced in seeking occidental healthcare, women's responses included lack of money, insecurity, men giving them means/permission, and having no president. The most common response was lack of means. Many women indicated that even if they could get a consultation, they could not afford the medications. A few women even went further, saying that even if they could afford the medications, they could not afford the food necessary to take with it. Women indicated that if they absolutely needed pay to go to a clinic or to buy medications that they would seek money from their family or community members; therefore, they often said that lack of

solidarity in their communities also acted as a barrier to accessing healthcare. A few women indicated feelings of humiliation at the hospital as deterrence for seeking healthcare. "When I explained the doctor my problem, he laughed at me," one woman said.

Having facilities is necessary, but not sufficient, to get women to use the healthcare system. According to PAHO, in Haiti the most important problems of healthcare access for women are the following: lacking money for treatment (75%), transportation/road access (35.8%), the distance to the facility (33.2%), and fear of going alone (22.6%). The fear of being alone is also a cultural reason why women do not go to healthcare facilities to give birth. Haitian women are used to giving birth in the presence of their family and friends in the home and hospitals generally do not allow women's families to accompany them. Fortunately, most women feel they know where they could go for health care (92%), and most feel they don't need permission to get healthcare (91%). While most women knew were they could find healthcare, 16.5% stated that the healthcare facilities they could access had no healthcare specific for women's health.

Women's perceptions of Justinian Hospital

Many women said that there aren't enough doctors and nurses at Justinian and clinics, that the doctors and nurses available do not *want* to take care of them and that they felt disrespected and/or humiliated when going to seek care at Justinian. Specific complaints were made about the facilities, the wait, sensitivity of medical staff and costs. In their responses, it was also evident that many women did not understand many of the treatments, medications and tests they were given.

In terms of facilities, women complained specifically about lack of toilet facilities. They also indicated that there are not enough health facilities to take care of all the patients. More than the number of health facilities however, women complained about not having health clinics or dispensaries in their neighborhood and that to have a consultation, get tests done, and get medications at different locations is too difficult, requires too much transportation and cost. One woman said, "It would be nice to have a clinic where you can go, and they can refer to the hospital if it's a real problem." They wanted all tests and medicines available at the hospital (especially because they said tests and medicines are cheaper at the hospital). Providers had many more complaints about facilities, including the comfort of the waiting area, the lack of flat pathways to transport patients on if necessary, the lack of electricity and the lack of running water in most services.

Women particularly were concerned with the wait and the way in which they are received at the hospital. Many women said that often no one welcomes there, they are made to feel guilty for being sick, and/or that they are completely ignored when they go to the hospital. In their words, there is a complete lack of 'prise en charge.' No one tells them were to go, no one informs them of what they need to do (such as get their records first), and often they wait for hours before anyone speaks to them. Many women complained that they can sit at the hospital all day and not be seen at all.

In terms of humiliation, women's interactions with administrative staff, nursing staff and doctors were points of insensitivity. Women said that they were laughed at, ignored, or not engaged (ie: the doctor would prescribe without explaining). One doctor said that even the consultations are humiliating for the patient: "When we examine them, anyone can walk in; it's like an open show. Do they complain? Of course not, but they feel it. If they have means, they would never come here [JUH]." Another provider said that whenever she sends a woman to the hospital and she asks afterwards what the doctor said, most women cannot identify what the medicines or vitamins the doctor has given them, do not know their health problem, and have no information on how to manage it. Many women claimed "taking medication without food can kill you." One doctor said

that they often try to explain, but that the language and education barrier makes it difficult. "How do you explain to an uneducated person a cardiac infarction?" she asked.

The most common complaint was cost. Even in emergencies, women said that they had to pay to receive emergency care. A few women spoke about their own medical emergencies while giving labor and said that they could not receive services without paying upfront. One woman said that she had been only 5 gourdes short, and the medical staff refused to give her the intravenous solution she needed. A provider explained that often they provide the first emergency medication, but that after the first, the patient must pay upfront. Another provider said that even for pediatric nutritional emergencies, all syrups and IVs must be paid for before treatment. While there is an emergency fund for pediatrics to use, there are no procedures with which to use it, so it often is not used at all. "We go to the doctor and go home with the prescription in our hand," many women said. They often cannot pay for their prescriptions and follow-up care, and their providers seldom ask if this is a problem. Some women indicated that the cost of obstetric care was a deterrent. One said, "If we are pregnant and go to the hospital, they automatically say, 'cesarean!' We cannot afford that." One key informant said, "The hospital always says cesarean. Our organization cannot pay for it, but many times the women don't really need it." Some women and key informants perceive that the hospital prescribes more expensive care without reason.

Barriers to providing healthcare

In the key informant interviews with providers, they were asked what their barriers were to providing healthcare. Many of their barriers included the same barriers the women faced, including: money (for supplies, and their families), adequate medical facilities, adequate human resources, cultural beliefs, traditional medicine, lack of education of their patient population and communication (both between patient and provider and in between healthcare providers – nurses, doctors and students). When they spoke of supplies, providers indicated that they often cannot find basic and necessary supplies such as prescription paper and gauze. One doctor said that she didn't even know that they had fixed the X-ray machines, and kept referring patients out of the hospital. Both doctors and nurses said they did not know what medicines were in stock, and that they often did not know where to send women for emergency supplies or medicines. However, the most important problem providers identified was the lack of human resources. They spoke about the overall lack of health providers as well as absenteeism.

According to both women and providers, the health system in Cap Haitien has too few human resources. One woman said, "When you go to the hospital is when the misses [nurses] tell you their problems." Nurses both at Fort St. Michel and at Justinian spoke about how the health system is undermanned, and that the cooperation between doctors, nurses, and the students (nursing and medical), is so bad, that even the people who do work do not do so efficiently. One nurse said, "The biggest problem is that it is really just us and the interns, and they are in the middle of their education. The residents stay in their rooms and ask us to call them – I don't have a phone, I won't walk to go ask them to come. We never see the doctors who are in service – if only when we give them their checks. The hospital functions, but it is abandoned." Some providers defended the absenteeism in the hospital. One nurse said, "It's not their fault, they must leave to go find money. They are signed into the hospital, but they are not here."

Some doctors indicated that the lack of human resources at the hospital has real repercussions on the outcomes of patient care. "Yesterday there was an emergency in the night. There was no surgeon at the hospital, though there is always supposed to be. He died. The parents didn't even know that it was wrong that he died – there is nowhere to complain and they didn't think of complaining. There're no doctors in the emergency room, even no nurses – it doesn't shock anyone. Life has lost

its value. Only when the internationals come, that is when you see them work," one doctor said. Another doctor spoke of how the lack of human resources makes it impossible to take care of more patients at the hospital: "If all the women wanted to give birth in an institution, with this 20% who do come, we are already overwhelmed. We can't take care of them all. Already too many come for the hospital to give quality care to. There are neither the people nor the facilities to take care of them."

Below is a chart comparing healthcare resources in Haiti, the Dominican Republic and the United States. The ratio of doctors and nurses to population is the least in Haiti as well as the health expenditure. This lack of human resources is partially due to the tendency of newly trained nurses and doctors to leave Haiti. Many providers spoke of colleagues who had left, and many providers that were interviewed lived partially in another country as well. One doctor interviewed said, "I have two children, they were born in the US. I made the hard decision to have my children in a country where at least they could be guaranteed schooling, and if they have means, they can actually have access [to healthcare and public services]. It's hard when you don't believe in your own country."

Table 2: Health facilities in Haiti compared to the Dominican Republic and the United States.

	Haiti	DR	US
Population	8.2 million	8.6 million	291 million
GDP per capita	$1,107	$5,792	$35,182
Total Health Expenditure/Capita	$56	$353	$4,887
Total Health Expend. as % of GDP	5%	6%	14%
Physicians/100,000	25	216	276
Nurses/100,000	11	30	782

10.5.3 Religion

There are two prominent religions in Haiti: Voodoo and Christianity. Women spoke about the health healing powers of both. Women were generally adamantly against Voodoo practices as medical care. Whether this response was because of the bias of the interview (all interviewers were practitioners of occidental medicine), or a conditioned response from years of anti-Voodoo stigma, many women indicated that they did not use Voodoo. Only two women indicated that they had used Voodoo health practices, one for a son who had mental illness, and one, a woman who had been "satanized" by her husband and had to get rid of the nightmares she'd had since his death.

However, many women indicated using their Christian faith as a form of health practice. They spoke of presenting their sicknesses at prayer groups, praying over infections, fasting, and asking for the priest's help in healing their health problems. When asked who they trusted or where they went for help, many women (and each focus group) said "God," "Jesus," or "Church." Especially the older women believed in the healing powers of religion. The older women often talked about fasting and prayer as means to cure health problems. Many women also saw their faith leader (priest or pastor) as health consultants – often seeking health information in their church groups or in discussion with their faith leader.

Along with religion providing healing capacity, some women indicated that infections and diseases had a religious nature. One spoke of HIV/AIDS as penance for sins. She said, "They must ask God to forgive their sins to get well." Another spoke of STIs being the repercussion of sexual sins. Women sometimes spoke of never being able to cure infections and diseases because they were given from God. However, these comments were few. Providers believed that these types of comments were the most common beliefs. Providers showed frustration in that many women did not believe in the biology of disease and would often not follow instructions because they believed

that their diseases or infections were God-given. One provider said, "One patient developed open skin wounds due to medication, but he believed this was God showing him that the disease was leaving his body – so he would not stop the medication." But while some providers saw their religious beliefs as possibly detrimental to their health, some women saw it as complementary to the occidental health system. "Health doesn't come on its' own, its' God who gives health. But I can clean myself, practice hygiene, I can do certain preventive measures," one woman said when asked how to maintain good health.

Public interventions have to take the religious context of Haiti into consideration. Most Haitians claim to be religious and according to the focus groups, women will believe the tenets of their religion and family first. Therefore interventions need to include the religious community, or need to work around the religious community in a way that does not contradict the religious context of Haiti.

10.5.4 Charlatans

Women spoke of two groups of charlatans: 1) those that sold medicines in the streets (including citotek – the morning after pill), and 2) those that performed abortions. Women spoke of them strictly impersonally. They often contextualized abortion as what younger women did who got pregnant to early, or what women did who were poor and had no choice (either by pressure from men or by lack of resources) but to have an abortion. They spoke of charlatans distastefully, often indicating that charlatans took advantage of the woman's position and offered the worst quality healthcare. Accordingly, charlatans were the choice of desperation, either from lack of money or lack of support. According to women they were "untrained" and used "dirty practices".

Providers generally agreed with the women's opinions, yet were frustrated that women would not come to seek occidental medical care first, as providers believed that the delayed medical care often incurred even higher costs than if the women were to seek healthcare first.

10.6 Reproductive Health

In general, women had meager understanding of their reproductive systems. Many older women did not understand that menopause was normal, all women believed that any discharge was abnormal, and some women expressed false beliefs such as children being born with their umbilical cord attached to their head, and the cultural belief of perdition which means that a woman can hold a baby within her (and bleed periodically) for years before the baby comes out. On the other hand, there was a strong understanding that promiscuity could lead to disease, that having too many children or having children too early could be dangerous for the health of the mother, and that having children was necessary socially to maintain respected stature as a woman.

There are many reasons for delayed or lack of access to healthcare in Haiti. In Barnes-Josiah's analysis of the 3-delays framework in Haiti, she shows the situation women face when they go into labor. The three delays are the following: 1) delay in seeking care when there is an emergency, 2) delay in reaching the appropriate obstetric facility, and 3) delay in receiving adequate care at that facility. While they are often delayed by the transportation or cost, when women do eventually get to the health site they need in order to give birth – the proper emergency procedures are often not available or not completed. This third delay suggests that, above all, there needs to be appropriate interventions available at the hospitals; else it is of little use to increase access to the facilities [1]. Barnes-Josiah's study on maternal mortality in Haiti, found that Haitian women often do not use western medicine when pregnant, and there is a strong culture of using traditional birth assistants (TBA). Between 60-70% of women are attended by TBAs when in labor. And 67% have at least one prenatal care visit from a TBA [1].

10.6.1 Fertility and Family Planning

One of the more common health problems women in the middle age groups stated (20-34 and 35-54) were both having too many children and having children to early. One woman explained, "There are three types of young women, those that know [family planning] methods and use them, those that do not know, and those that know, but do not use them because they think they won't get pregnant or because the man won't let her." Many of these women spoke of family planning as positive, however, many also said they didn't use methods because they either did not know where to access them, or a man wouldn't let them. Interestingly, side effects of family planning medications were very well known in some focus groups. Many women indicated that almost any pain or negative effect while using family planning was the fault of family planning. Overall, family planning (in medicinal form) was the only medication that women seemed to understand, giving gaining weight, and cramping as possible side effects.

Moreover, many women indicated that they wanted fewer children. These comments were often followed by statements about how they could not take care of their children, and their children could not take care of them. Some of the women recommended putting family planning centers near the markets where they could go while they shopped. When clarifying this recommendation with providers, providers said that women wanted to take their contraception in secret. If they came to the hospital, one provider explained, the husband would know they were gone for hours and would ask; therefore placing family planning centers where women often passed made it easier for them to seek the healthcare they needed without the limitations of their partner.

Providers believe that almost all women know that pregnancy can be prevented but that many do not know how. The most common forms of family planning used in Haiti are Depo-Provera, female sterilization, the pill, condoms and Norplant [3]. Most contraception is either provided free or sold at a token price according to providers at the MSPP and Justinian hospital. Depo-Provera is the most popular and providers believe that it is due to it's simplicity in use (only once every three months would the woman have to come in), its ease to hide (no one would have to see or know the woman was on contraception) and the woman won't forget doses.

While according to the MSPP, there is free family planning for all women, the service is both underutilized and often includes masked fees (such as initial consultation that costs $10). According to the UN, in 1999, the unmet need for contraception of Haitian women was 47.8%. The unmet need is further exemplified in the gap between desired fecundity (2.9) and the true fecundity, 4.5 children. Fortunately, the availability and use of contraception are higher in the northern area noted particularly with the increased rate of satisfaction with the family planning programs (46% in north while 41% in all of Haiti). While 28% of women in Haiti use contraception (22% use modern contraceptives), 32% of northern Haitian women use them (27% using modern) [4].

According to DHS, of women 15-19 years old, 14% already had children [3]. This was noted by providers as the primary reason that women do not finish secondary school. The difference between women's and men's wishes in Haiti is important to note because of the implications on women's health choices. So whereas 59% of women surveyed said they wanted no more children, only 29% of men agreed [4]. It is important to keep this in mind in family planning programs, as women expressed that there is pressure for them to fulfill the needs of their partners, in part because there is economic stability in maintaining a partner.

Women's contraception choice also alludes to truths about gender disparity. Where women have little say in contraception, they often choose a contraceptive not obvious to their partner. The most

common form of contraception in Haiti is Depo-Provera injection (12%); all others combined only form 15%.

Abortion
Almost every focus group mentioned young women "jete ti moun" or having abortions, generally due to pressure from a partner, or because of abandonment of the partner and fear of worsened poverty. Women would exchange horror stories of adolescent girls dying post-abortion and of those girls never confiding in their parents. "One girl had an abortion without telling her parents and died in her friend's house. Now her parents think her friend's family did something to her and blame the family, they do not know that she was pregnant even," one woman said. Some women also indicated abortion as something a woman would do when she was "Kadijacked" (raped – the term coming from the name of a historical French general in the army). It was specifically cited as a problem for younger women, but also often as a health problem for all women of reproductive age.

Some providers strongly supported the legalization of abortion. One provider said, "Even if it's illegal, women go to charlatans and have illegal dangerous abortions. They get rotisserie-d by whomever and come into the hospital and the resources we spend on fixing these women, or in losing these women [she shakes her head]." Another said, "Even in rape they cannot get abortions, so first they are forced to take in the man, and then they are forced to have his child, women bear the entire burden, the contraception, the sexual violence, the childbearing."

Abortion continues to be illegal in Haiti; however, illegal abortions continue to happen – and until the past year often at public health facilities, according to some providers. Out of the DHS women surveyed, 6% of northern Haitian women admitted to having had an abortion, .8% of those in the last five years [4]. Over half the children born in 1995-2000 were not desired by their mother [3], underscoring the gap that exists between what women desire in their fertility and their number of children.

10.6.3 Perinatal Care
Women indicated that pregnant women have the least problems in accessing healthcare. One woman said, "When you're pregnant is when everyone wants to give you care." Another woman said, "Pregnant women have no health problems, they will be seen by a doctor." However, many women in the focus groups did not have a good understanding of pregnancy. One provider said, "They receive vitamins from clinics or the hospital when they are pregnant, but they do not know what they are taking. They are not informed."

According to DHS, in northern Haiti, women are more likely to receive prenatal care (78-81% compared to 71-79% in all of Haiti), but less likely to have delivery assisted by a health worker or attend a hospital for delivery (16% assisted by health workers compared to 24% in all of Haiti, 85% birth in house compared to 76% birth in house in all of Haiti) [4].

10.6.2 Urgent Care
Many women mentioned emergencies as health problems, including: eclampsia and hemorrhage. In speaking of general health problems, many women listed pregnancy as a general health problem. Some women gave personal stories of going into labor and encountering an emergency. Three women spoke of having eclampsia, and one spoke of a family member hemorrhaging and dying. Often, however, they mentioned these problems impersonally; adding that there was no free urgent care, that there were not enough emergency care facilities and that they believed that in most cases, there was nothing to do when faced with an obstetrical emergency.

Some of the women gave contraception as a reason for hemorrhage. It seemed that women in the focus groups agreed with nodding and agreeing verbally. Contraception was seen as a risk to their reproductive health. Preventive methods to hemorrhage that women mentioned were having less children, not having children too early, and having cheaper (or free) access to emergency healthcare.

Some providers, specifically the obstetrics staff provided information on maternal mortality in Cap Haitien. One doctor explained that urgent care was more commonly needed at the beginning of pregnancy (post abortion), at the end of pregnancy, and during the postpartum period. According to the obstetrical nursing and medical staff, when women come in for consultation, either at Justinian or CDS La Fossette, they are made aware of signs of complications. But one problem many providers indicated was that while more women were coming for prenatal care, most women never come for postpartum care. There is no postnatal clinic at Justinian. And often, as women generally deliver at home, the complications are recognized to late, and the woman does not access healthcare in time. "The references are made late, and with an institution that lacks in trained personnel and equipment, it's hard to take care of these complications," one doctor said. Providers, as inside sources, were very critical of their capacity for urgent care. One NGO representative said, "It is impossible to get emergency transportation. They must pay personally, or carry them physically. However, they [Justinian] do admit any time of day or night." A doctor explained, "The patients have to buy the materials. The service does not give out anything to the woman. We only have one anesthesiologist. We must share the surgery room with the other services, we have priority, but if they are using the two rooms, we must wait. Obstetrical emergencies often can't wait. And the doctors can't give out the supplies, they can't pay either."

The highest proportion of women's ill health burden globally is related to their reproductive role. Universal access to reproductive health care – including family planning, care in pregnancy, during and after childbirth; and emergency obstetric care – would reduce unwanted pregnancy, unsafe abortion and maternal death, saving women's lives and the lives of their children [10]. The most common medical causes of direct obstetric death in developing countries are hemorrhage, complications of illicit induced abortion, pregnancy induced hypertension, infection, and obstructed labor (including ruptured uterus). In Haiti the most common causes of maternal death are obstructed labor (8.3%), toxemia (16.7%) and hemorrhage (8.3%) [3]. One out of 38 women in Haiti will die from causes linked to maternity [3].

While some recommend that through antenatal care, obstetric complications can be predicted and that high-risk women can therefore be carefully monitored and treated, high-risk women account for only a small percentage of all maternal deaths; the vast majority of deaths occurring in women with no known risk factors. Thus risk -screening programs have little impact on overall maternal mortality levels [11]. Evidence concerning the training of midwives or traditional birth attendants is somewhat convoluted because of the varying definitions and types of traditional birth attendants. In Haiti there seems to be traditional birth attendants (some trained, and some untrained), midwives (trained through an educational program), shamans as well as herbalists that can all be called when a woman goes into labor [1]. Maternal mortality (but not neonatal or infant mortality, in which the outcomes are quite different) is remarkably sensitive to standards of obstetrical care, but remarkably resistant of the changes in socioeconomic deprivation [12].

10.6.4 Infertility

While infertility was not a topic brought up in the focus groups, two key informants – one woman who had participated in a focus group and one provider spoke about their personal stories of infertility. The woman had one child and had not been able to conceive afterwards. The provider had not been able to have a child for a length of time before finally being able to conceive and have

a child. The woman said, "I cannot say anything about infertility, it's God who gives children. Sometimes men can poison someone so that the woman can't have a child, they use Satan." The provider spoke about the stigma of infertility: "To have a husband and not be pregnant is seen as bad. One friend lived with me, when I was married and did not have a child – I had adopted one, but none of my own – my friend got pregnant and left, and sent a card that was mean, pointedly taunting me about having a sour uterus. But then I got pregnant, and I called this friend and said, not only is my child well, but my husband loves her – that friend didn't have a husband."

All providers indicated that infertility has serious repercussions on women's lives, ending marriages, being shunned by family and/or friends, and that women often have no access to care. Some providers said that women believe that infertility calls for traditional methods, that they do not see the biology of the problem. One provider said, "Protestants will abandon the church to go to a hugan to get children – it happens often. They won't come to the doctor; they'll go to their community and ask for prayers. People will turn away from them." One provider said that the stigma comes primarily from other women. He said, "Polygamy is common. When a woman has a wife and a mistress, or two mistresses, and if the mistress has a child and the wife doesn't – this is a big problem. The mistress becomes much more important, more powerful. They lose their stature."

Some providers spoke about adoption being an option – but only for the people with means. Informal adoption, however, between family members is often done, but not necessarily for the reason of infertility but for poverty, when one woman cannot take care of her children, she will give them away.

While contraception tends to be the focal point of most family planning programs, there are little (and expensive) services for infertility. Providers said that there was no program for poor women who wanted children, that all fertility medications were very expensive; therefore only the richer Haitians can access infertility care. The woman interviewed personally said, "I went to Ofatma [a clinic], and they asked many questions about having children. I told the doctor I don't know why I don't have other children. He sent me to Carrefour Moustique to take a test for $520. I gave up because I didn't have the money. I never went back."

According to DHS, 99.6% of women in Haiti who have no children want to have children. Having primary sterility is associated with a 2.5 times higher rate of divorce (11.2% for women who are not sterile versus 27.6% of those who are) [4]. Childlessness and infertility have consequences for a woman's chances of being in a stable relationship, whether through lowering her chances of entering into marriage, raising her chances of being divorced or separated, or increasing the chances her husband will take another wife.

10.7 Communicable Disease

Communicable diseases can be subdivided into: sexually-transmitted infections (including HIV), acute respiratory infections (ARI), intestinal disease, chronic infections, vaccine-preventable infections and vector-borne infections. The infections and diseases that women could name were tuberculosis, malaria, HIV/AIDS, typhoid, worms, parasites, and filariasis. Otherwise, they often spoke of diseases and infections by their symptoms – such as 'difficulty breathing' for an ARI or colored venereal discharge for an STI. Older women were the least likely to be able to name specific diseases or infections. One older woman (55+) said, "When we were young, we had none of this, now everywhere we go, it's infections, infections, infections…" Many older women claimed that the infections and diseases that are common now in Haiti were not there in their youth, including HIV/AIDS, and infectious diseases such as malaria and TB.

Women mostly spoke of symptoms. They mentioned fevers, stomach pains, itchiness (skin and vaginal), headaches, overall weakness, venereal discharge and lower abdomen pains. Many of their infections were often called by symptomatic names, such as "gratelle" (itchy) for itchy skin, and "gran chale" (big heat) for venereal disease.

10.7.1 Sexually-transmitted infections

Almost all focus groups referred to venereal disease. Women spoke about either themselves and/or their daughters having colored, excessive and smelly discharge. "I have to walk around in a diaper I have so much discharge," one woman complained in a focus group. Often when one woman would speak about venereal discharge or pain in her vaginal canal, other women would nod and add their stories. Women referred to STIs as "itchy intimates," "discharge", and "heat in the intimates." They seemed to understand any amount of secretions as signifying an infection. In terms of causes, women often indicated promiscuity and bathing problems as sources of vaginal infections. Some women noted that condoms were a preventive measure against STIs. One woman, when asked how women could prevent STIs responded, "but for money women need men," indicating that even if women know how to prevent STIs, there are pressures that make them not use those preventive measures. Providers indicated that vaginal infections were one of the most difficult topics to broach with women. Many women are unwilling to accept that there are normal secretions, nor do they want to alter their sexual behavior out of fear of the men they are with. Both women and providers indicated that women were unlikely to share any information of their STI status with their partners. Women were reluctant to speak about STIs in the focus groups until one woman started the discussion, and often in younger groups, no woman would speak about STIs personally.

According to DHS studies, while 98% of Haitian women have heard of HIV/AIDS, 66% have never heard of other sexually transmitted infections. Out of those who do know other STIs (44%) only 49% can name symptoms [3]. Unfortunately, STIs are common in Haiti – and even more common in the northern area. While 15% of all Haitian women interviewed had an STI, 20% of northern Haitian women were infected [4]. Fortunately, 63% sought medical attention, which infers that women do have some agency to seek medical attention. 12.2% of these women had not told their partners [3]. The most common STIs are syphilis (11%) and gonorrhea (48%) [2].

A case study at Albert Schweitzer Hospital studied pregnant women, in which they found 2/5 women had an STI during pregnancy [5]. Another study in Cite Soleil (a slum outside of Port au Prince) showed a prevalence of 45% STI infection in post-partum women [2]. It is therefore important to note that different populations within Haiti have large disparities in their prevalence of STIs, which indicate that a range of interventions need to be created in order to stem the different contexts of STI infection.

HIV/AIDS

Three women openly spoke about their HIV positive status. One spoke about her children also being seropositive. The reactions in the focus groups were often to speak of other people they knew with HIV, or stories in their neighborhoods about HIV. There was never an open negative reaction to the women who were open about their status. Every focus group, on the other hand, spoke about HIV/AIDS, if not personally, impersonally – as a common disease that they were afraid of. They called HIV/AIDS "the blood infection." Some women (especially the younger women) gave blood (razors and needles), sex, and childbirth as methods of transmission. The older groups often did not know, or even seemed desperate in their lack of knowledge. One woman begged us to explain, she wanted to understand how HIV/AIDS could spread so quickly as she believed it did. Only one (older) woman voiced doubts about HIV/AIDS, saying she believed it was a curse, not a disease and that the health system was trying to make them scared. This last mention of HIV/AIDS is what

many providers indicated was a major belief in the population – that HIV/AIDS was a curse and that there was a general disbelief in its biological prevalence.

There are, however, various forms of HIV/AIDS education taking place in northern Haiti. Women spoke about VDH, FOSREF, MSPP and public health vans with bullhorns doing HIV/AIDS education. One woman said, "the information is there, some women just don't want to know." Providers felt the same, indicating that there were still social taboos that prohibited women from accessing the knowledge that would empower them against HIV/AIDS. While many providers said that women did not refuse to get tested for HIV when encouraged to do so, many women refused to share their status with their partner. One provider said, "it is not only women, neither women nor men want to disclose their status. There are no jobs here for HIV positive people; no one will invest in them. They are left to their families, and many of them do not want to be a burden." Another provider pointed to the fact that many Haitians are trying so hard to survive, that the stigmas around diseases are part of their self-preservation: "You can't find a job if you've had TB, even if you're cured. You can't find one if you're HIV positive. This is on a background of poverty and survival, it's not that they hate that person – it's ignorance and survival instincts. They want to preserve their life – they have five children to raise. Even if it looks inhumane, it is the reality."

Haiti has the highest rate of HIV/AIDS in the western hemisphere, with 83% of all HIV/AIDS cases in the Caribbean located in Haiti [5]. According to PAHO, 7-10% of sexually active adults in urban areas are HIV/AIDS positive (compared to 3-5% in rural areas). Even worse is that among sexually active female teenagers in urban areas, the prevalence is increased to 7.4% [2]. Knowledge of HIV/AIDS is high, with only 2% of women claiming never to have heard of the disease [3]. Unfortunately the understanding of the disease is questionable, with 20% believing that it is transmitted by sorcery (30.5% unsure if it is sorcery), and 35.3% knowing the disease but not knowing any means by which to prevent contracting it [3]. In northern Haiti, HIV/AIDS knowledge is even worse, with 54% of women not knowing how to protect against it [4], and 62% of women in the north having not changed their sexual patterns to avoid the disease (compared to 56% in the overall population). Furthermore, only 50.3% of women cited condoms as a preventive measure, and only 59.4% cited faithfulness [3].

The disparity between men and women's knowledge is also evident in the understanding of HIV/AIDS. While the comparison in northern Haitian men to overall Haitian men shows the same result – that the information about HIV/AIDS is less known in the north, men still have a much better understanding of the disease. Only 36% of them have not changed their sexual activities to avoid HIV/AIDS, and only 32% do not know how to protect themselves against HIV/AIDS [4]. Stigma seems to also be a strong factor in HIV/AIDS treatment in Haitian culture, with only 50% of women saying they'd be willing to be tested, only 21% of women agreeing that HIV/AIDS patients should continuing to work other people, and only 30% saying that they'd be willing to take care of an HIV/AIDS infected family member. Confounding the lack of will to get tested is that only 22% of women would know where to get tested [3].

10.7.2 Acute Respiratory Infections

The most common way women spoke of ARIs was symptomatic. ARIs generally came up in reference to their children, not themselves, and were mentioned as breathing difficulties and severe coughing. The women strongly linked ARIs to the environment either by stating that ARIs came from "breathing in trash [from the streets]" or from flooding of their homes. "When it floods, we mothers stand outside and cry, our children get sick," one woman said. No women cited any ARI by name, but often mentioned ARIs in their demographic interview when asked when they last sought health care for themselves or a family member. When the health problem was a respiratory problem,

they often first tried teas, then medicines from charlatans, and in cases where this was not enough, they sought medical attention at a clinic, dispensary or hospital.

In the DHS study performed in 2004, 39% of children under 5-years-of-age had suffered from an ARI in the two weeks preceding interview. ARIs were more common in rural areas than urban areas (43% compared to 32%). Households where the mother has an education level of at least secondary school or higher have lower caseloads of ARIs in children (33% compared to 40%). In northern Haiti, 43.5% of children under 5 had had an ARI in the two weeks before interview, and 60.1% had not sought out occidental medical care. 50.9% of children with ARI in the north were treated with syrup or medicines bought directly by the family, 43.9% sought traditional medical care, and the rest were not treated at all for their ARI [4].

10.7.3 Intestinal Infections

The intestinal infections women spoke of directly were typhoid and worms. Upon further questioning, women seemed to clump all parasites into their concept of "worms." Otherwise, women often spoke of stomach pains, intestinal pains and pain due to eating in the focus groups. Diarrhea was never brought up in focus groups although a few women spoke about their children having diarrhea during the demographic interview. Women indicated that "stomach pains" came from bad water, bad food and insects (specifically flies and mosquitoes). They often could not distinguish which stomach problems came from which cause. Some women believed that typhoid was mosquito-borne. Many women indicated that typhoid included both stomach pains and fever. Almost all women knew that drinking impure water caused stomach/intestinal problems. Women generally used traditional teas as their first attempt to alleviate the symptoms. They often did not seek medical care until they had tried home remedies and bought medicines from charlatans. None of the women spoke of specific cures or occidental medical practices to help their children.

According to the DHS study done in 2004, the prevalence of diarrhea in children under 5 was 25.7%, 31.9% in the north. As seen with ARI prevalence, diarrhea prevalence is lower in families with more highly educated mothers (22.6% compared to 25.9%). Over 99% of women knew of oral rehydration therapy for diarrhea [4].

10.7.4 Chronic Infections

The most common chronic infection in Haiti is tuberculosis, and it was the only one women could cite by name. The incidence of TB in Haitians is estimated to be 180 per 100,000 inhabitants. It is estimated that 19% of TB patients are HIV seropositive and that 50% of HIV/AIDS patients are TB positive [2]. In 1995 there were the first cases of multi-drug resistant TB.

One woman, in the oldest age group (55+) suffered from leprosy. She said that there was nowhere she could go in the area and that the only medical care for her infection was in PauP. She, herself, did not know the name of her infection, and when asked if a doctor explained it to her; she said no, that they only referred her to a specific health center in PauP. She cannot afford to go. Between 1993 and 1996, 521 cases of leprosy were reported to PAHO [2].

10.7.5 Vaccine-preventable Infections

None of the women spoke of vaccine-preventable infections (such as measles, diptheria, polio, hepatitis, and tetanus). Providers often mentioned that vaccination campaigns were the only public health campaigns they believed were truly successful, and wished to find a similar method for family planning and prenatal care. However, according to DHS statistics, only 48% of children under two years old in the northern department have completed their vaccinations (compared to 34% in all of Haiti), and 10% of children have had no vaccines whatsoever [4].

10.7.6 Vector-borne Infections

Vector-borne infections, after STIs were the most commonly mentioned in focus groups. Women spoke the most often about malaria by name, but also mentioned filariasis. Many women spoke of "big feet" of their children, or themselves as a health problem, referring to elephantitis. Often, even if they couldn't name the infection, many women spoke about mosquitoes as threats to their health and the health of their children. Again, many women seemed to know that infections came from water and insects (they mentioned mosquitoes and flies), however, they could not distinguish the different causes with the different infections. Many of the women indicated that keeping flies and mosquitoes out of the house was a way to stay in good health, however none of the women mentioned decreasing standing water, mosquito nets or repellant.

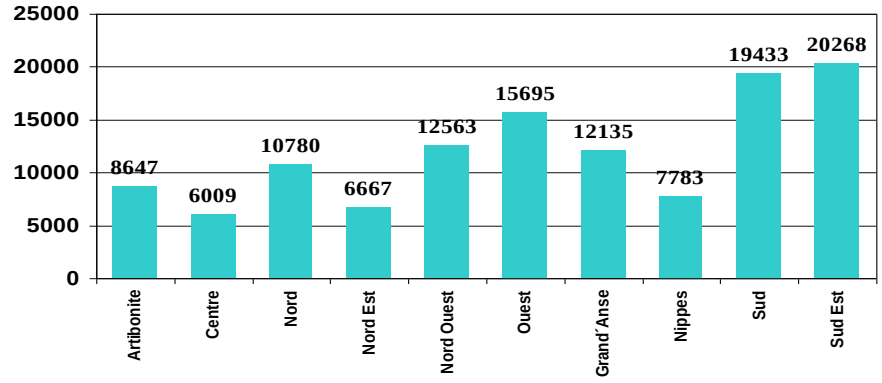
One team member came down with malaria during the interviews, but quickly sought medical attention. Overall rates of malaria in Haiti are estimated at 5-10% in high seasons with a mortality rate of 1% (wetter seasons) [2]. Thus far there has been no incidence of drug resistant malaria and therefore chloroquin is still the standard drug. Dengue fever is endemic in Haiti with serotypes 1, 2 and 4 present. Lymphatic filariasis is most common in the north and costal urban regions (including Cap Haitien) with 20% of the population being carriers [2] and 5% of the population suffers from elephantitis of the foot.

10.8 Non-communicable Disease

The non-communicable diseases that women mentioned were "sucre" (sugar), meaning diabetes, hypertension and heart disease. They were often mentioned as being health problems for elderly women, however hypertension was also mentioned for women of reproductive age. One specific focus group was held on the third floor of a building, and one woman came in angry that we could be insensitive to her hypertension and make her climb two flights of stairs. The older women often spoke of the symptoms of these diseases as some of their main health problems, dizziness, trembling, overall weakness, and headache. One woman said she wished she could work but that with her trembling she cannot sew anymore. Only one woman throughout all the focus groups mentioned "eating too much" as a cause of disease. A couple of women mentioned exercise as a preventive measure. The women never mentioned obesity, however it was mentioned as increasing by some providers.

Providers indicated that it is non-communicable diseases that are on the rise in Haiti. And that without proper prevention methods, that the burden of disease will become similar to developed countries with more of the health expenditure focusing on diseases such as cardiovascular disease, diabetes and hypertension.

Hypertension: Distribution of cases *detected by the Network of the Cuban Cooperation*, by department, Haiti, 2003



Hypertension: Distribution of cases *detected by the Network of the Cuban Cooperation*, by department, Haiti, 2002

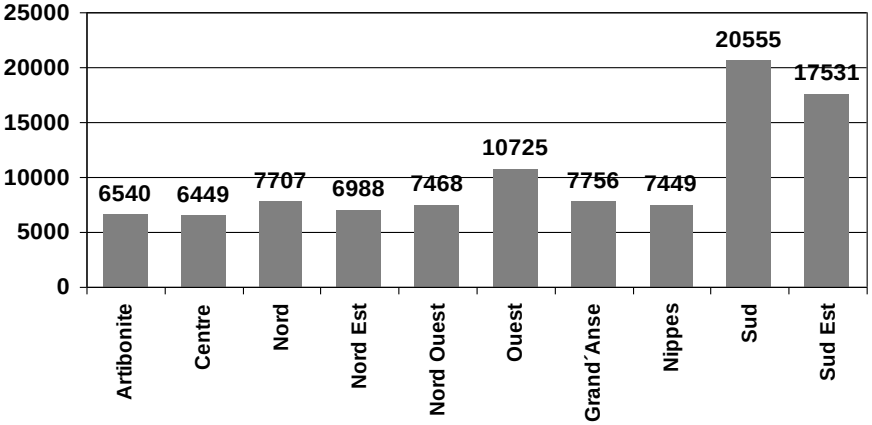


Figure 1: Hypertension prevalence in Haiti in 2002 and 2003, by surveillance by the Cuban Cooperation, PAHO [6].

The cost of treating these diseases is of great concern to some providers, specifically those that work with NGOs. One provider said, "Most women don't take their hypertension medication because it's a constant price they can't pay, and the women don't understand that the less they control their diabetes, the more expensive the treatment is."

According to PAHO, the estimated prevalence of diabetes is 2-8% with 50% not being diagnosed. The prevalence of cardiovascular disease is 40% with 70% of those cases being associated with hypertension. PAHO's surveillance shows that hypertension is increasing (Figure 1). Obesity, while increasing in Haiti, is still the lowest prevalence in the western hemisphere, at 2.8% prevalence (2.6% in women) [7]. Better education is associated with increased obesity [8]. Populations in urban areas have higher obesity prevalence than rural areas (4.8% versus 1.4%) [8].

10.9 Mental Health

Almost each focus group mentioned some aspect of mental health. The most common mention of it was when the women were asked what the main problems were for elderly women. Women would say, "they lack peace," "sadness," and "they can't sleep at night, they think too much." Overall, however, it was a common health problem mentioned by the focus groups. Most providers said that women do not see mental health as a problem. However, one provider said, "they will tell you that to be healthy everyone around them needs to be healthy." A woman said, "If a woman cannot find work and provide for her children, she spends all her time reflecting, it can influence her health." Another woman said, "The economy plays a very important role on mental health. If we are poor, we cannot be in good mental health." Women indicated that having a job, being able provide for their children, having strong faith, and having their close relatives healthy were preventive methods to having good mental health. They also mentioned the insecurity in the country, and the stress it caused as being factors in their ill mental health.

Providers said that women were very hesitant, if not adamantly against, being diagnosed with a mental health condition. Patients refused medication or care, and there is a large stigma against

mental health. One provider said, "they think if they have a mental health condition, that you are calling them insane, they do not see the different variances in mental health. If you tell them they have a mental health problem, they will ask, 'do you see me throwing stones at people?' it's only recognized when they're delusional, aggressive, or depressed to the point of dying, otherwise, it is all considered normal. They are raised depressed." Another provider said, "I sometimes think that some of the women who come to me are depressed, but it's hard to distinguish because you're dealing with malnourished people, so their energy is low anyhow." Providers also indicated that mental health was perceived as a mystical health problem – therefore necessitating traditional healers and not occidental medicine. One provider explained that Haitians are strongly against suicide. There is a saying, he said, "better be ugly and alive." Another provider said that the only form of suicide she had witnessed was when older women would choose to fast until they died. It was often due to terminal illness or depression or a general feeling that their life was at its end.

In Cap Haitien there are no psychiatrists. There is one visiting psychiatrist that comes once a month to open his private clinic for patients. To attend his clinic is 100 Haitian dollars ($20). One of the key informants for this study was a psychologist that works in Cap Haitien, she said that it is very difficult to even offer psychological care to a woman, "they will think you are calling them crazy."

According to PAHO, Haiti exhibits an increase in reported mental disorders precipitated by sociopolitical crisis, unemployment, violence, social unrest and drug use [2].

10.10 Cancer

Only in two focus groups did women mention cancer by name. When followed up, they didn't seem to understand what it really was, what caused it, or how to prevent it. Women were more likely to mention ovarian and uteral cysts, again not being able to give any more details. Some providers, specifically doctors, were concerned that cancer in women, specifically cervical cancer, is a growing problem and that there is very little effort going in to educate women on the problem.

Haiti exhibits similar cancer trends as the developed world. The number one cancer killer of women in the developing world – including Haiti – is cervical cancer [5]. Women in Haiti are overrepresented, presenting 55% of all cancers in Haiti [5]. The treatments available in Haiti are limited to surgical resection or excision and the National Cancer Institute was established in 1988 to collect data on Haitian cancer epidemiology. The NCI has reported that 40% of women's cancers are cervical, with the second most common cancer being breast cancer at 30%. The third most common cancer is nasopharynx cancer that infects 10-15% of women who have cancer. Interestingly, over time the proportions have changed: cervical cancer has dropped from 60% in '89 to 40% in '94; breast cancer has risen from 15% in '89 to 30% in '94 [2]. These shifts can be either due to true shift, which is unlikely to have changed this drastically, or changing methods of diagnoses and increased breast cancer detection.

10.11 Physical Conditions

In each focus group general physical conditions such as blindness, deafness, and overall weakness were mentioned. They were specifically mentioned as problems of the elderly, and the older women gave personal accounts of their difficulties due to their worsening physical conditions. Many older women complained that they "knocked their feet together" because they could not see, that they could not work because their vision was worse, and many younger women said that their elders could not hear. No providers mentioned these physical conditions as problems. One provider said, "You will see that specialties that are expensive, like radiology or ophthalmology do not exist. It is because even the doctors cannot afford to have these specialties. They cannot afford the equipment." None of the women interviewed wore corrective lenses or hearing aids. About her

overall weakness, one woman said, "I cannot go to the latrine anymore; I have to go to the sea, because I cannot bend down anymore."

There was no information or aid source for elderly women that women or providers mentioned. None of the other NGOs contacted or in partnership with Konbit Sante had specific services for elderly women. Accordingly, there are little services for vision, hearing or aging that were known to any of the contacts.

10.12 Recommendations

Recommendations from women focused on increasing access to care. They recommended decreasing prices, opening health clinics in different neighborhoods, better referral systems, and an increase in the number of community health workers. Providers, while mentioning similar recommendations, focused on quality of care. Providers indicated the need for diversification and better facilities, to better provide healthcare to women, including a surgery room for the maternity ward, more anesthesiologists, better general and medicinal supplies, better organization of the hospital and better community health education. Many providers also indicated the need for increased involvement of women in their own healthcare. One doctor said, "We practice medicine without even asking the patient how she is, we do not listen to her." The doctors interviewed, after facilities, prioritized increasing the quality of communication between the patient and doctor. Nurses on the other hand prioritized the organization of the hospital, both in terms of facilities and personnel. Specifically, they recommended increasing the capacity of the healthcare providers to work together, both across services and across hierarchy (doctors, nurses, students).

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VIII. International Community

The international community affects all aspects of human security in Cap Haitien. Within the first level – many international organizations provide basic needs, including immediate health needs, food, water, shelter and immediate security (MINUSTAH, WFP, Sacred Heart Nutrition Program, Meals and Food for Kids, etc.). On the second level, within community needs, many international NGOs are also working in community building (VDH, FOSREF), sustained security (MINUSTAH) and public services (Konbit Sante). Possibly, the international community is present the least on the third level of human security, future needs, in terms of long-term employment opportunities, increased educational standards as well as professional standards and livelihood strategies. The international community also has an effect on how some women in Cap Haitien feel about their own community. One woman spoke of the tourist industry that is currently all but gone in Cap Haitien. "I used to have a beautiful life in Cap Haitien. There were always tourists who came and I was proud of my city," a woman said before shaking her head and looking at the ground.

There has been a strong presence of NGOs in Haiti since the 1980's. In 1996, Haiti already had over 400 NGOs working in all different sectors, and currently there are over 700 [1]. This intricate and generally disconnected web of providers for different services often impedes efficiency and effectiveness of both government and non-governmental groups [1]. Specific to the health sector, only one third of Haiti's 663 health institutions belong to the public sector (and even many of those are aided by private funding) [3]. By 1995 almost 80% of all public spending in the health sector in Haiti came through international funding, increased from 50% in 1992 [2].

Questions about internationalization were posed to the key informants. They were asked how Haitians perceive the international community, how to improve the programming of international NGOs, and how they think the international community perceives Haiti. Topics they discussed included migration, health, income generation, and services provided by or through international funding and organizations.

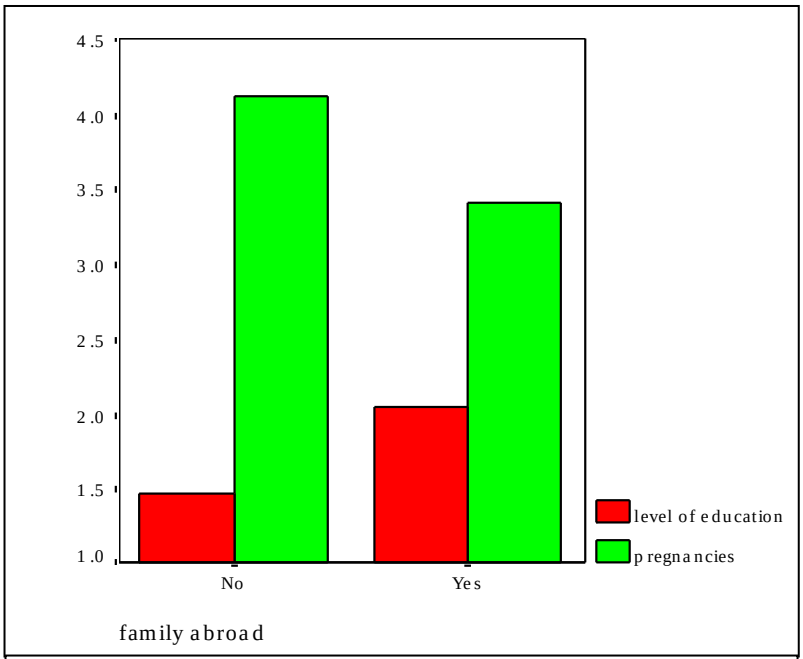

Figure 1: Number of pregnancies and level of education attained according to whether or not the woman has family abroad(n=183). Having family abroad was not related to age.

The women were not directly asked about the international community in the focus groups. However, during the demographic interview, they were asked if they had family living abroad and if they were financially or materially helped by family abroad. Twenty-three percent of the women interviewed indicated that they had family members abroad (parent, spouse, sibling, child) and 13% said they were helped financially by family members abroad. Within the 183 women interviewed, those with family abroad were likely to have fewer pregnancies and had reached higher levels of education than those who did not have family abroad (Figure 1).

Women and providers spoke very differently about the international community, which may be due to differences in direct exposure. Many providers interviewed had consistent contact working with international donors or NGOs while many of the women were participating in an internationally funded program without knowledge of international backing. The only direct reference women made about international influence was the effect of immigration on their communities. While women generally spoke of the international community in terms of fulfilling basic needs (income generation, food and clothing), providers focused on the international community's relationship to socioeconomic issues – this difference similar to the way women and providers spoke about women's problems in Cap Haitien.

7.1 International aid and immediate needs security

Though women were not asked specifically about the international community, there were instances when women spoke either directly or indirectly about the effects of the international community on their lives. Specifically, women spoke about the international community's effects on clothing and income generation. Some women spoke about the international textile factories that had been in Haiti but had left, and how they wanted them to return.

International food aid and clothing donations came under scrutiny. Two providers expressed anger at the international community for "dumping their agriculture" onto Haiti instead of investing in local capacity as well as their opinion that the clothing donations undermine the women who sew as a means of income-generation. An NGO representative spoke about the oversight from the international community. "They used to make their own clothes, they don't anymore. They don't grow their own food… The idea is to make people self-sufficient, not to make them dependent on you. And they call it aid." However, in the four focus groups where donated clothing was discussed by the women, no woman complained about clothing or food being donated – conversely, they spoke about the donations positively because they paid less for those donations and could use them for income generation. Therefore the complexity of how to provide aid increases when the opinions of providers and women are placed side-by-side in determining recommendations.

7.2 International aid and community security

Women also spoke about the effects of the international community on their local communities. Specific issues they discussed were the breaking up of families and communities, help from family abroad, and education. They spoke about their families breaking apart and moving, and not being in contact with their own children or grandchildren. They mentioned the Dominican Republic as a place for husbands to find work and children to go to university and find work – most being unsuccessful according to the women's stories. However, women seemed to believe that having family abroad had positive effect. "I have no one in another country that can help me, only Jesus," one woman responded when asked where she could go for her basic needs.

Providers spoke in detail about the problem of broken families. Specifically they spoke about husbands leaving and bringing back STIs, of women having no power in the household, and of parents leaving their children behind (in Haiti) and those children having more health problems – including mental health problems.

While these population movements were not blamed on the international community, it was indicated as a significant part of Haiti's interaction with other countries. Women indicated that the problems in Haiti forced people to leave the country, but that success was not found elsewhere. "We need work and universities in this country, because they kill the youth who go to Santa Domingo." The women even referred to the 'brain drain', or the immigration of educated people out of Haiti: "In this country, the people who finish their studies don't want to do whatever which work."

7.3 Overall perceptions of international involvement

The general aspects of international involvement that key informants mentioned were: military, women's rights, and health. Generally the key informants believed that international military involvement was on the whole negative and did not help at all. They praised the international community for helping elevate the status of women, and they generally believed that the international community provided necessary and good health services. However, there was criticism about international donors and agencies excluding the beneficiaries in their programming, racism of donors and in programming, lack of efficiency, and some skepticism over the intentions of international programs. Overall, providers agreed that while the international community hasn't changed life for women in Cap Haitien, there are more opportunities and options offered, especially in health, and especially in reproductive health. The providers believe that current programs are so singular and fragmented from other similar and potentially complimentary programs and that there has been very little large-scale change. Despite their criticisms, many key informants indicated that although they wish the international involvement were enacted differently, that without international involvement the services (and even the country as a whole) would collapse.

7.4 Perceptions of international involvement in health

The women spoke about the international community and health only indirectly. They referred to internationally funded hospitals and clinics as better, such as VDH, CDS La Fossette,Vaudreiulle, and Milot. They preferred these privately, internationally funded clinics to the public alternatives. The marginalized women were not alone in their preference, as providers and women with more resources also preferred these internationally funded clinics.

Providers said that those with means (often including themselves) would either go to PauP or leave the country to seek medical care. "We lack facilities to do many of the necessary operations, so people who are educated know that Justinian doesn't suffice. But it's the only hospital in the department, it's not good enough for those with means," one provider said, "The poor come because they have no choice, they don't know it should be better. But they still know that they should be treated better and with respect – that is why hospitals like Milot and Pignon are more popular. They are cleaner, more efficient, offer more than the minimum, and respect the women. Even if it's more expensive, the women will prefer to go to them." Providers spoke about how not only medical services were better with internationally backed institutions, but that the best community health education was also provided by international NGOs.

"Haitians have no respect for public services. There is more trust in foreigners to direct institutions than there is in Haitians," one provider said, summarizing what many providers spoke about. Many key informants believed that both funding bodies and beneficiaries preferred "white" people to manage services. "Once the white man leaves, the people won't come anymore [for services]," one provider said. One key informant who is Canadian had frustrations in passing her organization to Haitian ownership and management. Every time she left, it seemed that the beneficiaries were more hesitant to participate.

The international community is present in every sector, but the key informants believed it is the most present in the health sector. They believe that one key difference in the public sector versus the international or private facilities is that of absenteeism. "At Milot, the doctor works 8-5 and knows he will get paid only if he works 8-5. At Justinian, he'll work 8-10 and make the same as if he stayed all day," a doctor said. The management and pay in the public sector were the main issues brought up by medical providers.

A few key informants perceived a lack of efficiency in international organizations. They indicated that the people directing and working for the programs in Haiti take all the money, and that not enough is spent on actually providing services. However, those complaints were generally followed by statements such as "at least they provide quality services, whereas the public system is inadequate." Specifically, providers spoke about the impact of the international community and reproductive health services. "The global community has been persistent enough to create a positive attitude toward family planning," one doctor said. They believe that the global community is emphasizing women's health issues and that this is affecting the way women in Cap Haitian perceive health care. However, one doctor was skeptical about the emphasis on family planning, "Are they just sterilizing Haitian women to stop them from coming to Miami?" he said. He explained further that most Haitians perceive international organizations and foreigners with a mix of skepticism and trust – they believe them to provide better services, but do not trust the intentions.

Praise is stronger and less skeptical for HIV/AIDS. Two key informants work directly with the international community in implementing HIV/AIDS programming. Both believe that without the international community that there would be much less support for HIV/AIDS and significantly more stigma. One HIV/AIDS psychologist spoke about how the international community was the key actor in decreasing the stigma as well as offering healthcare to HIV/AIDS patients.

7.5 Perceptions of Konbit Sante

"In pediatrics, what Konbit Sante has done has improved services so much. It makes us embarrassed. You came here and did it for nothing, and we could not do it for ourselves. People die for nothing. There are no doctors in the emergency room, there are no nurses. There is no conscience until the internationals come. When you internationals come, we work, we are here on time, we are embarrassed," a provider said. Providers all believed that Konbit Sante (KS) has made improvements at the hospital. Some providers indicated that some KS programs have not worked out as the providers thought they should (such as electricity for the operating room, or the emergency medication and nutrition program in pediatrics). Nurses spoke about KS's technological help, specifically internet and electricity – they complained about the inconsistency of both. While key informants that were hospital-based seemed very pleased at KS's performance thus far, key informants from the community, while still pleased that KS was helping improve public services, criticized some programming aspects of KS. One key informant attributed the gap between what was programmed and what was delivered to lack of direct management from KS staff. In discussions about KS with all key informants, many attribute more to KS than what KS has really accomplished; i.e.: many believe that all electricity and internet at the hospital is provided by KS.

7.6 How do internationals perceive Haitians?

All providers indicated that the image that internationals have of Haitians was negative. Many providers feel condescended to, both by foreigners and by funding organizations. Some believed that to get funding it was better if one was a foreigner, that funding organizations will not give money to Haitians. Providers said they wished NGOs would help the local infrastructure and liked KS because of its mission to build local capacity in the public health system.

7.7 Recommendations from providers

"Right now the internationals decide how they come. The internationals need to listen to Haitians, let Haitians plan for themselves, and not enforce only their personal interests. Give a chance to this country," a provider said, a bit forcefully. Other providers echoed the same sentiments in their interviews (specifically providers who worked with international funding). Providers emphasized the need for self-determination and empowerment in programming. They believe that if internationals

do not trust in Haitians, the Haitians will not believe in their own capacity – which some providers indicated was already a problem.

Providers also criticized international organizations for imposing models that have worked in other countries, that don't work in Cap Haitien. One doctor spoke about reproductive health programming, saying that the international community has developed standard models that they take from country to country and that there is little, if any, effort to contextualize the programming to Haiti. In his opinion, programming will not work unless it takes into account the local culture. Another criticism was that these organizations emphasize quantitative outputs instead of the quality of care. "There are many programs that fail because they are not given the time to work, like maternal morality, there are means to decrease it, but they are not numerically efficient," a doctor said. The providers emphasized the need for international organizations to emphasize quality of care and programming that is sensitive to the specific population and their needs.

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IX. Recommendations

The overwhelming response from both providers and women was the need to be "pris en charge" – a French term that has no sufficient translation in English, but comes close to being a mix between empowerment, advocacy and taken-under-the-wing. While women prioritized feeling empowered in their ability to fulfill the basic needs of the family, providers focused on the need of women's empowerment in choosing how to live their lives and to be able to control their own healthcare. Providers also indicated the need for empowerment in the health sector as well – to be able to provide the healthcare. In synthesizing both sides, the most agreed upon recommendation would be to emphasize empowerment in programming.

9.1 Empowerment

Empowerment is defined generally as the "means by which people experience more control over decisions that influence their health and lives [1]." This has become a more common explicit goal of development programming. The World Bank states "programs for growth monitoring and promotion and for micronutrient supplementation are acknowledged to work best when communities and local governments are involved in their design and management [2]." Along with the emphasis on empowerment comes an emphasis for decentralization of power and resources, particularly finding methods of decentralization appropriate to the particular environment. The World Bank stipulates that the most effective nutritional programming must be multisectoral – not housing nutrition in one sector, but instead separating the multiple goals of nutritional programming among the sectors such as agriculture, health, education and employment [2].

Health programming policy makers have always struggled between 'bottom-up' and 'top-down' approaches. The first is more focused on community empowerment while the second generally is more consistent with disease prevention – focused on the outcome regardless of behavioral change. With indicator-based evaluation, the top-down approach attracts many programmers because it facilitates the need of benchmark achievement. The bottom-up approach, based on empowerment, requires participatory programming, monitoring, and evaluation – a system that is not yet (nor easily) integrated in donor-capacity for program management [1].

In Haiti, all sectors are strictly centralized in the capital, Port au Prince (PauP). For employment in the Northern department in the Ministry of Health, Ministry of Agriculture or Ministry of Public Works, all employment appointments must be made through the central offices. Currently all payments are made through the central offices in PauP as well. This has been a struggle for many private-public partnerships as well as international NGOs and the public sector. Women spoke of their hope that with the new administration that was voted on in February, that there will be effort in decentralization to promote and enhance the capacity for increased access to health care and nutrition in all the departments. In Cap Haitien, Konbit Sante works directly with the Ministry of Health (MSPP). Healthcare programming cannot succeed if the women's prioritized needs continue to be unfulfilled. Therefore, it seems that empowerment programming will have to start slow and work alongside the slowly decentralizing infrastructure of the Haitian government.

Increasing empowerment in communities generally takes more time, is harder to evaluate, and includes beneficiary participation in all parts of the programming – indicator outlining, goals and methods. Traditional programming planners chose indicators based on health – i.e.: decrease of parasites or increased anthropometric measurements for nutritional status. Empowerment programming is hard to measure and generally must include an ongoing qualitative measurement of how the community feels they have (or have not) control on their nutritional status.

Because of the longer time periods and more integrative monitoring required for empowerment programming – it has often been implemented on a small-scale instead of large-scale. Unlike disseminating vaccines all over a country (an intervention both women and providers referred to repeatedly) – empowering women to provide food for their families takes much more investment, time, training and evaluation – for this reason, there have been NGOs in Cap Haitien who target small groups of women, either through cooperatives or religious groups, but large-scale empowerment in health programming has been difficult to implement to date. There is too little financial and personnel investment, too small of time requirements from funding organizations and too little logistical capacity for empowerment as of yet.

9.2 Monitoring in empowerment programming

Kilby argues that although development programming has adopted the theme of empowerment as a vital role to all programming; it is not actually being implemented. The reason for this, he argues, is the focus of donors on quantitative indicators [3]. Chambers argues that: "Drives to disburse funds by deadlines, and to spend within fixed periods, weaken or kill participation, ownership and local self-reliance, undermining social networks and leading to low quality in programs [4]." Further more, the focus on measurable indicators using tools and processes which are externally derived shifts the focus away from the beneficiaries and NGO constituents and is therefore disempowering to those who are meant to be empowered.

Because empowerment involves more than material and economic objectives, specifically including psychological, capacity and community dimensions, indicators are hard to identify and must be context specific rather than externally determined and standardized. Within Haiti – the women need to be part of the process of creating the benchmarks not only for their nutritional needs, but their empowerment needs as well. Monitoring and evaluation techniques need to be integrated into the programming so that a constant re-evaluation and focus on re-programming exists so that women have the ability to participate in all levels and feedback groups so that the programs are the most effective, sustainable and integrative.

9.3 Empowerment Recommendations

9.3.1 Education:

9.3.1.1 Case-specific: All health providers should do case-by-case education and inquiry. When a patient presents with a particular illness, be it airborne, waterborne, STI or injury, the health provider should take that opportunity to discuss the ailment with the patient (in confidence if possible since many providers and women indicated that women could not talk freely in front of others and indicated that they were often embarrassed by the lack of confidentiality in the hospital). The health care provider, whether it be nurse, community health worker, or doctor, should discuss the origin of the ailment, preventive methods and make sure to do so in a language that the patient understands (as providers indicated that there is a language barrier between the Creole-speaking people and the French-trained doctors) and methods should be used to ensure that the patient understands the recommendations and advice of the health worker.

9.3.1.2 Community Groups: Public health education campaigns should be implemented in both existing community groups (such as those that Justinian health workers have already organized, Fort St. Michel groups, as well as women's cooperatives or church groups) and in newly created groups to educate communities about environmental health issues as well as specific disease prevention methods. Older women especially indicated that they did not know much about preventive methods. While many women indicated that there were "microbes" in water, food, and on the ground, their specific disease knowledge was very low as well as their knowledge of methods to prevent infection.

They should be taught water purification systems and ways to diminish the amount of standing water around their homes. The community groups could also be used for case-finding of endemic diseases, and facilitation of mobile clinic services or visiting nurses or doctors. These groups should also facilitate dialogue among women to allow them a forum in which to speak. In this capacity, groups would have to be separated by gender as women indicated that they could not speak freely in front of men. Women thanked Konbit Sante for the focus groups repeatedly saying that no one had ever asked them what was wrong, or wanted to know what they thought. Therefore, using the groups as a forum of discussion as well as education will allow women to share their frustrations and problems so that they can relieve some of their burden.

9.3.1.3 School-integrated education: Reproductive health should be integrated into the school curriculum. If possible, it should be integrated into primary school since there is a significant drop-off of enrollment in secondary school. Providers indicated that women coming in had no understanding of their own organs and had no sexual education. Basic biology should integrate basic infectious disease into the curriculum so that all children, before finishing primary school, have information on prevention methods that are based on scientific knowledge and not just health education. If they are taught about the organisms that create infection they will be more empowered to make educated decisions to use preventive methods.

9.3.1.4 Desensitization: One of the barriers to disease treatment and prevention that providers indicated was the stigmas and misunderstandings of disease. Specifically, AIDS is either seen as a mystical curse, or if understood to be a disease, is treated with fear and shame so that people 1) hesitate to get tested and 2) do not disclose their status – not even to their partners. Other diseases that are misunderstood and stigmatized include epilepsy and any mental health disorders. Education campaigns should include these misunderstood and stigmatized diseases so that women are more likely to get tested, prevent transmission, and seek treatment.

9.3.2 Income Generation

9.3.2.1 Cooperative-building: Along with facilitating women's groups and other groups for public health education and case-finding, groups can work together to form cooperatives of agriculture, sewing, artisans, and public works (including community clean-up and volunteerism – either in health, food, water, etc). These cooperatives can apply together for grants or work with local or international NGOs as well as the public sector to generate income for the participants in the cooperative.

9.3.2.2 Urban Agriculture: As some women and providers indicated, the people in Cap Haitien have largely lost their ability to grow and buy local foods. CARE International has done urban agriculture programs in Port au Prince using community space – such as public parks and beachfronts, and small areas in private homes to plant local fruits and vegetables. Along with the agriculture, composting methods should be taught to decrease the burden of waste. Other waste such as plastic containers and tires can also be used as plant holders. This agriculture will at least give women the ability to grow some of their own food – and if in cooperatives, families can partake in sharing different crops to benefit the whole group's nutrition.

9.3.2.3 Micro-financing: Because women don't generally have the income to begin the cooperatives or industries mentioned above – there needs to be partnerships with local or international banks and micro-financing groups to work with cooperatives of women. If possible micro-financing programs should integrate the public sector as much as possible, respective to the industry they are supporting. Micro-financing agreements should be as long-term as possible, since known micro-financing programs in Cap

Haitien have shown positive results but the women have not yet become independent. Financing should be sustainable as to not undermine the participant's trust in the system.

9.4 Health Services Recommendations

The goal of the needs assessment – to obtain an understanding of how women understand their health problems and how they approach the health systems allowed for women and providers to speak about their understanding of the health facilities accessible to them. Below are the recommendations for the health facilities and health staff.

9.4.1 Inventory

9.4.1.1 Pharmacy: Providers complained that drug supplies were allowed to expire and that there was no keeping track of which drugs were and were not in stock. Women preferred to get their medications at the hospital, because of both convenience and lower costs. Therefore, there must be an inventory of drug supplies kept in the pharmacy that would include all drugs, and intra-venous solutions.

9.4.1.2 Fuel: Power outages in the hospital facilities are common and have interrupted surgeries. While separate generators are used in some departments, such as Family Medicine and Surgery, services must be prioritized so that electricity can be conserved and used efficiently. While the computers in the family practice unit may be important, it is more important to ensure that surgeries do not get interrupted with power outages. Since some of the generators at the hospital are fuel-run there must be a constant inventory of fuel that is used to inform the operations room manager who schedules the operating rooms.

9.4.1.3 Supplies: Konbit Sante has been donating supplies to Justinian Hospital for over 5 years now. Every shipment is emptied into the supply rooms which are 1) disorganized, 2) unlabeled and 3) not efficiently used. While Konbit Sante has tried to keep an inventory of what is donated, there has been no inventory kept on the other side – of what supplies the Justinian has, what they need and what should be used first. To prioritize what is needed in the donation shipments, as well as to facilitate the services in the hospital, inventory of supplies must be kept and distribution procedures documented so that each department of the hospital can prioritize what they need and have access to it in an organized fashion.

9.4.1.4 Macro-inventory: The Ministry of Health should facilitate a women's resources conference where NGOs, public and private facilities that work with women would attend. The agenda would include taking an inventory of which services each group provides and creating a referral system with which providers could disseminate the needs of the women to the most appropriate facility. Organizations such as FOSREF (works with adolescents), AFSDA (works with women's advocacy in domestic violence), Sacred Heart Center (nutrition), Fort St. Michel Clinic, MOFAPA (women's commerce cooperative) and Justinian Hospital should be included.

9.4.2 Health staff

9.4.2.1 Triage: Women complained that patients at the hospital are seen in chronological order instead of by who is the sickest. Although there is triage in the emergency room – most cases that come to the hospital are generally serious, as most women and providers indicated that they do not go to the hospital unless they've tried other methods that have failed. Therefore, the hospital staff may want to triage patients in each department depending on need of the patients.

9.4.2.2 Waiting time: Women were frustrated by the time spent in the hospital waiting, especially when they did not get seen at all. Medical admissions staff should indicate

approximate waiting times to allow for patients to leave if needed (understanding that they will lose their place if they are not present when their time arrives). It may be helpful as well if medical staff know the approximate time that each type of patient might take – i.e.: how long a tuberculosis (TB) consultation takes versus malaria versus STI, etc. This way they may be able to budget their time more efficiently. Finally, it might be better if the medical admissions staff keeps a maximum number of patient seen a day so that women can be told from the beginning of their visit if they will not be able to be seen. There needs to be a schedule of how many doctors, nurses and residents will be working at all times to inform the schedules.

9.4.2.3 Use of admissions staff: Hospital admissions staff should be trained in some basic medical capacity. For example, they should be able to read TB tests, look for phenotypic signs of malnutrition, etc. This will help them triage and allow them to interact with patients on a deeper level that could include, hopefully, some basic knowledge transfer. This way, even in the waiting room, patients can interact with the admissions staff to ask some basic questions about their health that the staff would be trained to answer. There is a lack of centralized admissions. There should be a centralized area where all patients are admitted and then referred to other units in the hospital.

9.4.2.4 Including beneficiaries: Hospital staff should be periodically have workshops on the priorities and needs of the beneficiaries (patients) of the hospital. While providers and women agreed on some needs and priorities, there were many gaps in what both sides believed about the other. To better serve their patients, all levels of hospital staff should be shown and taught, and hopefully participate in collecting information, about how the people in the community they serve feel about their services as well as health in general. Konbit Sante and the Conservation of Food, Environment and Health Foundation have supported this endeavor through this study to inform health practitioners of the priorities and health beliefs of women in the community. Up till now there have been no satisfaction surveys or any information collected on the satisfaction of patients who receive services at the hospital. Though there is interest on the part of some providers, there needs to be an organized effort to periodically assess the quality of services provided to the patients through their perspective.

9.4.2.5 Patient confidentiality and respect: Both women and providers spoke about the embarrassment and humiliation women often felt with health providers. All levels of health staff should be trained to treat the patient as a whole person and respect the ailments of each woman. When examining a woman, health staff should be respectful and it should be done with the most possible privacy – with either curtains or separate rooms if possible. Health staff should not expect women to understand their ailments, nor should they expect them to be uneducated – instead they should treat the woman with respect, ascertain what they know and educate them if they lack information. This will increase the comfort of the women, increase their willingness to seek care, and decrease stigmas related to disease and negative feelings of the hospital.

9.4.3 Infrastructure

9.4.3.1 Toilet facilities: Toilet facilities should be maintained properly and kept clean. Older women especially complained about their inability to squat and the need for real toilet seats. If possible, the hospital should make better toilet facilities available to patients. In other clinics outside the hospital, there are generally no toilet facilities at all for patients.

9.4.3.2 Bus and Ambulance: There are vehicles whose uses are undefined. The Justinian bus and ambulance, up till now, are not generally used for patient services. The ambulance should be used for patient transport and there should be an access number for patients. The bus could be used for community health seminars or physician visits in the community (mobile clinic). However, both often stand unused in the hospital parking lot.

References:

[1] Laverack, Glenn and Ronald Labonte. "A planning framework for community empowerment goals within health promotion." *Health Policy and Planning,* 2000. Vol. 15(3): **255-262.**

[2] World Bank

[3] Kilby, Patrick. "Empowerment in a Results-Based Project Environment: is it an impossible Task?" Working Paper submitted to the *Journal of Development and Management*. July 29, 2003.

[4] Chambers, R., Pettit, J. and Scott-Villiers, P. 2001. "The New Dynamics of Aid: Power, Procedures and Relationships," *IDS Policy Briefing 15,* Sussex.

X. Discussions and Moving Forward

After conducting three presentations of the results of the needs assessment at Fort St. Michel, the Cap Haitien MSPP office, and the Justinian Hospital, discussions were held with the participants to go over recommendations and ideas for moving forward. The discussion groups were largely composed of doctors, nurses, community health workers, NGO representatives, women and key informants who had participated in the interviews. While the discussions were with different groups of participants, there were four main themes that the discussions had in common which were:

1. Need for education: specifically for the women, but also the training of medical staff to serve the women population better.
2. Need for communication: between providers, between NGOs, better communication with women patients, problems with language differences (French and Creole)
3. Need for better inventory: of medicines, materials, and macro-inventory on different providers of health services, public, private and NGO-run.
4. Need for better management of Justinian Hospital: in terms of the wait, the reception, the integration of services, and absenteeism.

The discussions brought about many small arguments, accusations, and pieces of information about the healthcare providers. At the MSPP, the head of the MSPP in the north told the discussion group that there is a working list of NGOs in the areas and a description of who they serve and what services they provide, however this list is not complete and is not distributed. At the hospital, nurses spoke about the pharmacy stock manager who is not a nurse or a doctor, and actually does not know medications. Doctors accused each other of absenteeism and mismanagement of personnel, and nurses and residents spoke about bearing the brunt of the labor. At each meeting, the only participants on time were the women, followed by the NGO representatives and nurses, followed by the doctors. This was spoken about in one of the discussions, that the health providers disrespect timeliness the most – to which some providers suggested they do health education seminars in the morning when the hospital is supposed to start at 8:00 a.m. but the health providers don't arrive until 9:30 a.m. It produced some laughter, but many providers were honest about the absenteeism and problems they see at the hospital. However, many providers claimed that they could not be held responsible for all the problems but that it is the culture, the society that causes the majority of the issues.

At the end of each discussion, participants were invited to join the committee that would continue to meet under the auspices of Justinian Hospital in collaboration with Konbit Sante to work on women's health issues as they pertained to the hospital, the MSPP and local NGOs that wanted to stay involved. The committee has continued to meet and work on what they determine are their priorities. Below are discussed the priorities spoken about throughout the different discussions.

10.1 Education:

The need for education came up first in the discussion about the 3 delays to healthcare: 1) do women know they need healthcare? 2) can they get to the health service they need? 3) when they come to find health services do they find the care they need? Many discussion participants indicated that education was the most important for the first question. Many providers believe that the women do not know when to come in for healthcare. And that even if they know they have a health problem, there are cultural stigmas and taboos to overcome before they come see a provider at an occidental medical service.

The second piece about education was about training of the health care providers. Most are trained in French, and therefore cannot explain medical practices in Creole, the language of the patients. Many residents spoke of how often the doctors are not at the hospital to provide training. And nurses spoke of how they did not know what was going on in the different units of the hospital – therefore referrals were never followed up on, and the movement from patients from one unit to another often caused the patient to leave altogether. During the discussion recommendations were made about improving the training of residents through more hands-on training from the doctors and rotating the nurses through the different units to integrate the different parts of the hospital and increase the efficiency of referrals.

10.2 Communication

The first aspect of communication that needed improvement, per the discussions, was the communication between health providers. The nurses, doctors and residents alike spoke about how each service in the hospital was completely disconnected from other services, how there was little, if any, communication between nurses and residents and doctors, and that the health providers at the hospital had no idea of what other private and NGO-run health services provided, and vice versa. There is an isolation of each sector and each level of hierarchy in the health service system. The NGO representatives do not understand what services are available and the costs at the hospital, just as the doctors do not know where to refer their patients for NGO support in nutrition, education and micro-finance.

Even within the hospital, doctors spoke about not knowing what medications were in stock, not knowing if the x-ray machines were working, and not knowing what materials were available. And within the MSPP, doctors did not know what services and information the MSPP provided. The lack of communication frustrated all discussion participants equally. It led to accusations in the discussions, the passing of responsibility, and a current isolation that leaves most health providers frustrated and unable to fully help their patients.

The second piece of communication that was a theme in the discussions was the need for better communication between healthcare providers and patients. It was brought up that doctors and nurses are trained solely in French, and therefore do not know how to explain in detail medical problems in Creole. One doctor spoke of how hard it was to explain a cardiac infarction in Creole – she doesn't know how to do it; and equally the patients have no idea what it is. The disparity in the education of the women patients and the healthcare providers creates a barrier of communication that providers as well as women are humiliated by and do not know how to fix.. Some residents recommended having Creole medical seminars to discuss how to treat patients in Creole. But many providers indicated that women needed to be educated so that they know French. The one doctor who spoke about cardiac infarctions said that even if they found Creole words to describe it, an uneducated woman would continue not to understand, especially the complexities of chronic disease.

10.3 Inventory

The inventories that were specifically discussed were: medications, supplies, and health services. Providers reflected the women's concerns in wanting to know what health services were available at the different health centers. Many providers did not know what VDH and FOSREF (two health facilities that work with adolescents in health education, family planning and reproductive health) did. They did not know that there were nutrition centers where they could refer patients. They hardly knew what services the other hospitals had to which they could refer to patients. And more importantly, some doctors said they did not even know what their own institution provided. The

NGO representatives echoed the same concerns, not knowing where to refer their women for services, whether public, private or other NGO.

Many participants spoke about the hospital medical supplies, including medications, and that there was no updated inventory from which the nurses and doctors could supply themselves or refer patients. Often providers would refer patients out to dispensaries when they later found that they had the supplies available. There is no effective tracking system for the supplies at the hospital as of yet, which was a concern voiced by all groups of healthcare providers. Participants in the discussions suggested better inventory, both at the micro-level, to keep track of medications and supplies at each center, as well as macro-inventory, such as the MSPP creating a database of all health facilities and NGOs and their services.

10.4 Justinian Hospital

All of the discussion participants had exposure to services at Justinian Hospital, and many of the providers (nurses, doctors and community health workers) were employed there. Therefore many of the discussions, especially the discussion that was held at Justinian Hospital, were centered on Justinian's services. Specific problems that were brought up about Justinian were: the patient wait, the reception of patients, the integration of services, and absenteeism of healthcare providers.

In terms of the wait and reception of patients, many providers indicated that there were too many patients, not enough human resources and not enough financial resources. One nurse spoke about how in maternity they used to try to see all the patients that came to the prenatal clinic (and there would be 40-50 a day), but in an effort to improve the care each woman received, they limit their visits to 15 women per day now, so that the other 35-45 must leave and come back another day. Therefore, they've chosen to spend more time educating and caring for each woman, but a majority of the patients who come wait all day, do not get seen, and do not get an appointment. There are no appointments at the hospital, unless for a private patient of a doctor who invites them to come to their practice at the hospital.

There is also no central reception in Justinian. Each patient makes his/her way to the unit they think they need to go to, and from there they are either referred to another unit, or they are told to go get their records and come back. Many new patients who do not have their records often just leave, according to some nurses. Another nurse pointed out that most of the patients cannot read, and that therefore having written signs does not help, but that there needs to be signs with pictures. When the patient does make it, with their records, to the correct unit, there is no triage, but a chronological wait. Many patients come early, stay the whole day, are never seen by a doctor and are barely spoken to by any hospital staff. Many providers recommended either a centralized reception, having a person actually guide a patient until they are at the correct service with their records, and signs with pictures instead of words. Other providers recommended using the patient waiting areas as a forum for health education, or decreasing the wait by possibly giving appointments. However, many of the discussions often returned to speaking about how there are too little human resources for the amount of patients that come for services.

Discussions of lack of human resources led to discussions of absenteeism. One resident said that unless a program paid doctors more, that the doctors would never stay at the hospital to work their full shift – but that they would continue to leave to work at their private practices to earn more money. Some providers recommended that even if the doctors did not give their full 4-8 hours a day at the hospital, that each doctor should at least keep regular hours that they could be depended on to be at the hospital to see patients and train residents. When asked who kept track of the doctors' schedules, or the nurses' schedules, there was no answer. According to the discussions, there is no

effective method of ensuring that hospital employees work their hours, just as, according to providers, there is no way of ensuring that they get paid by the public health system. Therefore the problem of absenteeism was treated by most providers as something embarrassing, detrimental to patient care, yet necessary because of the instability of their income.

Many providers recommended the integration of services so that units of the hospital could learn from one another. Nurses could be familiar with all the health services in the hospital, doctors could learn about managing their units by sharing with others, and that the whole hospital could work in better coordination for the efficiency of the providers and the benefit of the patients. Some providers spoke about past efforts of committees formed, and meetings had, to integrate health services which had not worked. They asked for leadership to help them make the committees responsible and effective. And some asked for financial assistance to make larger changes such as a centralized reception or increased human resources. Overall, however, the providers agreed that there needed to be better integration of the public health system, within the MSPP and its clinics and hospital and with NGOs and the private hospitals and clinics.

10.5 Conclusion

After the three discussions, a list of about 20 interested persons was created and given to the Konbit Sante Program Manager in Cap Haitien, Dr. Coulanges. The committee to work on women's health includes NGO representatives, doctors, nurses, residents, and representatives of local women's groups. The group will be subdivided to work on different priorities as they choose fit. Konbit Sante will work with the sub-committees and larger groups to find partners, both financial and programmatic, to implement the changes and recommendations the hospital staff and community partners want to make. Local public health staff, either at the MSPP or Justinian, will maintain the leadership and design of recommendations and programs, to ensure local capacity building and sustainability.

Appendix 1: Focus Group Questionnaire

Women's Health Needs Survey
Focus Group Questions

Welcome and thank you very much for participating in the Women's Health Needs Survey. All of the information that is gathered here today will be used in the development of women's health programs and to improve the care you are receiving now. Now I would like to ask you a few additional questions in a focus group format. Focus group is a casual format where each one of you can provide additional information based on your own opinions and wishes about things that might improve women's health in your community. All of your comments are confidential. **Bienvenue et merci d'etre la et de bien vouloir repondre a cette enquete sur la sante des femmes. Toutes les informations obtenues ici aujourd'hui seront utilisees pour le developpement des programmes de sante de la femmes et pour ameliorer les soins que vous recevrez. Maintenant j'aimerais vous poser quelques questions en petits groupes. Chaqu'une pourrait exprime son opinions propre concernant la condition des femmes dans votre communaute et ses idees pour l'amelioration des conditions. Tous ce ques vous dites ici est confidentiel.**

Ground Rules for the Focus Group **Les reglement des groupes**

1. In focus groups there are a lot of different opinions. There are no right or wrong answers – just your own opinions. **Il y a des opinions differentes. Il n'y a pas des reponses bonnes ou mauvaises. Chaqu'une de nous a ces opinions et a le droit au respect des autres. Toutes responses sont bonnes**
2. It's OK to react to each other's comments. Some of you may agree with each other and some of you may disagree. **C'est normal de reagir aux commentaires des autres. Certaines peuvent etre d'accord d'autres non. C'est important de dire tout vos opinions.**
3. Let's all try to respect each other's different cultural values, beliefs and opinions. Everyone is entitled to their own opinions so it is very important that everyone be heard. **Essayons de respecter les valeur culturelle differentes, croyance et opinions. Chacun de nous a ces opinions et a le droit au respect des autres.**
4. Please try to talk one at a time so the group hears your opinions. We don't want to miss what you're saying. If people start side conversations with their neighbors we miss out on what's being shared. **Essayez de parle une personne a la fois. On veut pas manquér ce que vous ditent. Ne parlez pas avec vos voisins sinon vous allez rater ce qui est dit.**
5. All of your comments are confidential. What we say in this room stays in this room. Can everyone agree with that? **Tout ce qui est dit ici est confidential. Ce qu'on ditent ici reste ici, d'accord?**
6. Your participation is voluntary. It is OK to choose not to answer a question if it is uncomfortable for you if you like. **La participation est volontaire, et si vous ne voudriez pas repondre, vous n'avez pas besoin de repondre.**

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1. What problems do women face in Cap Haitien (free-listing)? (Probe: family, community, education, health, gender issues) **Quels sont les problemes auxquels les femmes font face au Cap Haitien? (liste ouverte examples: familial, communautaire, educattion, sante, inegalite entre les sexuelle, conjugal, etc.)**
2. Priority exercise: **Les Prioritaires: (Les premier trois)**

3. What are the most important? **Quels sont les plus importants?**
4. What are the most prevalent? **Quels sont les plus communs/courants?**
5. What has the most impact? **Lesquels ont plus d'influence sur la vie de tout les jours?**
6. What are the causes for these problems (problem tree for above listed problems)? **Quels sont les causes de ces problemes?**
   - Expected answers: mize (poverty), school, food, housing (social economic answers)
7. Where can women go if they encounter this problem (list options to each problem)? Where would the go first? Why? **Ou est-ce que les femmes peuvait allez pour ce probleme? Vers qui se tournent les femmes en premier qui vivent ses problems? Et pourquoi?**
   - Expected answers: family – family size important demographic indicator

8. What does being healthy mean to women in Cap Haitien (list of characteristics)? **Que est ce que ca veut dire etre en bonne santé pour une femme ici?**
9. What are the most pressing health needs of women here? (Probe: diseases, family planning, nutrition, reproductive health/pregnancy, mental health) **Quels sont les problemes de la sante les plus importantes des femmes ici? (maladies, planning familial, nutrition, sante reproductive, grossesse (prenatal, accouchement, postnatal), sante mentale etc.)**
10. Priority exercise: **Les Prioritaires: (Les premier trois)**
11. What are the most important? **Quels sont les plus importants?**
12. What are the most prevalent? **Quels sont les plus communs/courants?**
13. What has the most impact? **Lesquels ont plus d'influence sur la vie de tout les jours?**
14. What are the causes for these problems (problem tree for above listed problems)? **Quels sont les raisons/causes de ces problemes?**
    - Expected answers: mize (poverty), school, food, housing (social economic answers)
15. Where can women go if they encounter this problem (list options to each problem)? Where would the go first? Why? **Ou est-ce que les femmes peuvait allez pour ce probleme? Vers qui se tournent les femmes en premier qui vivent ses problems? Et pourquoi?**
16. Where do they get their information about this health problem? (media, mothers, in-laws, health workers) **Ou trouvent elles les renseignements dont elles ont besoin concernant au probleme sanitaire (mere, media, radio, informations, famille proches, agents sante, gueriseurs traditional, personnes sprituels, famille lointaine, infirmieres au corps medical)?**
17. What preventive of treatment solutions do you know for this health problem? (problem: preventive medicine is uncommon – better to ask: How can you avoid disease? How can you stay healthy? How can you get healthy when sick?) **Que savez vous a propos de la prevention de ce probleme? Comment prevenir une maladie? Comment rester sain? Comment faites-vous pour vous soigner?**
18. What do you think are the most important health problems of young teen-age women (jen fil) in the Cap Haitien community? **A votre avis quells sont les problemes de sante des jeunes filles ici?**
19. What do you think are the most important health problems of elderly women (gran moun) in Cap Haitien's community? **A votre avis quells sont les problemes de sante des femmes agees ici?**
20. What do you think are the most important health problems of reproductive aged women (just famn – reproductive age means little) in Cap Haitien's community? **A votre avis quells sont les problemes de sante des femmes en age reproduction ici?**

21. What are the barriers to getting health services (list – probe)? **Quels sont les obstacles pour obtenir des soins de santé?**
    22. Where do these barriers come from (problem tree listed items)? **Que sont les causes de ses obstacles?**
23. Who do women trust for health information (list)? **En qui les femmes ont confiance concernant leurs problemes de sante? Sante maternelle? Sante femme? Sante urgence? Sante maladie?**
24. For what health problem would women go to the hospital or any public health service? **Pour qu'elle raison de sante une femme ira t-elle a l'hopital? A une clinique ou a un service de sante publique?**
25. For what health problem would women go to a traditional healer? **1) Pour qu'elle raisons ira-t-elle chez le guerisseur traditionelle? (economique, ecoutes plus entensives, attention) 2) Pour quel problemes…**
26. What are the differences between western medicine and traditional medicine (list – probe: cost, services, perceived effectiveness)? **Quelle sont les difference entre la medecine occidental (medecine moderne – hopitaux, centre clinique) et la medecine traditionelle? (prix, services, satisfaction, efficace)**
27. How have things changed since you were children? **Comment les choses ont elles change depuis votre enfance? Pour le mieux? Pour le pire?**
    28. What has gotten better?
    29. What has gotten worse?
30. If a women's program could do only one thing to help women in the community, what would that be? **Si un programme pour femme pourrait changer seulement une chose pour les femmes, a votre avis qu'est ce que cela devrait-etre?**
31. If a health program could work with only one aspect of women's health care, what should that be? **Si un programme de sante peut changer seulement une chose, a votre avis, ca devrait etre quoi? (Pour les medecins: Si un programme de sante decide de travailler dans l'un de ces domaines de sante, a votre avis, ca serait lequel?)**
32. Can you describe the ideal kind of environment you would like to see in a health program for women? (Probe: provider, staff, atmosphere, services, and procedures, childcare, counseling.) **Pourrez vous decrire l'environment ideal que vous aimeriez avoir dans un programme de sante des femmes (personnel, services, ambiance, garde d'enfants, psychologue etc….)?**

**** Who within your community, who is well-respected and well-informed on women's issues, do you recommend us talking to to better understand women's needs in your community ?**

Appendix 2: Demographic Survey Form

DEMOGRAPHICS:

1. What is your actual marital status? (Circle one)
   A. Single
   B. Married – living together
   C. Married – not living together
   D. Have a partner and live with them
   E. Have a partner but don't live with them
   F. DIVORCED
   G. SEPARATED
   H. WIDOW

2. How many pregnancies have you had? _____ How many live births have you had? _____ How many are still alive? _____

3. How old are you today? (write in number of years)
   #__YEARS OLD

4. What was your approximate household income during the last month? _____

5. How well does the amount of money that you have take care of your current essential needs?
   A. VERY WELL
   B. FAIRLY WELL
   C. POORLY
   D. DON'T KNOW/REFUSED

6. How many people live with you in your household? (specify the number)
   #People in household___

7. How many years of education do you have? ____

8. What is your highest level of education? (Circle one of the letters)
   A. A FEW PRIMARY SCHOOL YEARS
   B. GRADUATED THE PRIMARY SCHOOL
   C. A FEW HIGH SCHOOL YEARS
   D. GRADUATED HIGH SCHOOL
   E. TECHNICAL SCHOOL (what type _____)
   F. A FEW COLLEGE YEARS (SHORT TIME COLLEGE)
   G. GRADUATED COLLEGE (SHORT TIME COLLEGE)
   H. A FEW UNIVERSITY YEARS (UNIVERSITY STUDIES)
   I. **GRADUATED UNIVERSITY (UNIVERSITY STUDIES)**

***ask until the first negative response**

8. Where do you get your potable water?
   a. Home plumbing
   b. Public well
   c. Buy from the store
   d. Home well

9. Do you have a radio? ____

10. Do you have access to a TV? ____

11. What type of sanitary device do you have?
   a. Flush toilet
   b. Outdoor latrine
   c. Public latrine
   d. None

12. If you have children, are they in school? ____

13. Do you have family outside of Haiti? ____ If so, do they send aid? ____ (Money? Food? Clothing?)

14. Health Incident History: **Tell us about the last time you or one of your dependents needed to seek healthcare of any sort: who was sick, what was the sign that they needed health attention?, where did you go first (family? Someone in the community?), how did they get there, what did they experience, if the first place didn't work, where did you go next?, etc.**

ORAL RECRUITING SCRIPT

Women's Health Needs Assessment in Cap Haitien, Haiti

Hi, I'm MaryAnn Dakkak and I'm a masters student at the Harvard School of Public Health in Boston in the US. This is _____ who is working with me on a project to find out about women's health needs in Cap Haitien. We would like to talk to women in Cap Haitien about women's ideas about health and ways that health services might be improved to better serve women.

We'll bring people together in small groups to talk about these issues. We'll form groups of about 8 people and we'll schedule the discussions here at the Centre Nutrition Sacre Coeur. The discussion will take about an hour and a half and we'll try to schedule the meetings so that they're at convenient times. We'll have refreshments during the discussion and each participant will be reimbursed to cover her transportation and time spent for the meeting.

This is part of a women's initiative in Cap Haitien and we hope that it will help the people planning services to design them so that they reach the people who need them most.

If you think you'd be comfortable talking about this, we'd love to have you participate.

Does anyone have any questions?

If you think you might like to participate, let us know after this meeting. We'll ask you a few questions: your age, and whether you have any children, to help us to form groups. You are welcome to ask any additional questions you have when you talk to us. Then, if you are still interested, we'll let you know on what date and at what time we'd like you to come for a discussion.

Thanks for your time.

INDIVIDUAL RECRUITING FORM

Women's Health Needs Assessment in Cap Haitien, Haiti

Hi, I'm glad you're interested in participating. Do you have any questions about participating? Okay, I'd like to ask you a few questions so that we can put you in a group that has other women who are similar to you.

You do not have to answer any of these questions. You can skip any questions.

How old were you at your last birthday? ___ ___ Years

Have you ever given birth? Yes/No
Are you currently in school? Yes/No
Aside from your own housework, are you currently employed by a business outside the home? Yes/No

Groups:

A. 18-25
B. 25-35
C. 35-45
D. 45+

Fill in the date/time listed above for the appropriate group:
Would you be able to come to a discussion on _____ from _____ to _____?
[DATE] [TIME] [TIME]

IF YES: Here's a card with the time and date to help you remember. Thank you for agreeing to participate, we're looking forward to talking with you more.

IF NO: Thank you for your time. If you are interested, we will be holding meetings in November to discuss the findings and you are welcome to attend.

INFORMED CONSENT FORM

Women's Health Needs Assessment in Cap Haitien, Haiti

You are here today to take part in a focus group discussion on women's health. We want to talk with you today about the different kinds perceptions, uses, and barriers to health services that you know about and what you think about them. The focus will be on health needs of women of different age groups, perceptions of health care and how to improve health services. The research is part of Konbit Sante's women's health initiative and we hope it will aid the ministry of health here in Cap Haitien. Our goal is to find out more about why women use different kinds of services so that those services can better address women's needs.

The group discussions will take about an hour and a half and there will be about 8 women participating. We've tried to make the groups so that you're talking with other women who are about your age.

We'll ask that everything that's discussed within the group stays within the group and we won't be sharing what you say with other groups or anyone else. We will ask all participants to respect each other's privacy and keep all information discussed confidential. We'd like to tape record the discussion but if you or anyone else in the group does not want us to do that, we won't. We will take notes on what is said but we won't attach names to statements. The only people who will hear the tapes or read the notes are the research team members here today and a translator.

If at any point you do not want to answer a particular question, feel free to not participate. We won't ask you to talk about anything you're not comfortable talking about. At the end, we will give you some information about the available services we know about women's health. You won't receive any payment for participating but we will give reimburse you to cover your transportation costs and any time commitment costs.

Participation is voluntary and you may leave the discussion at any time. Refusal to participate or leaving the discussion will not involve any penalty or the loss of any benefits to which you are otherwise entitled.

This study may help other women in Cap Haitien by guiding the development of policies and programs that better meet with needs of women.

While we will ask everyone to keep the information discussed within the group, we cannot control the women who participate and it is possible that something you said could be shared with others.

If you have any questions about the project or about your participation, this card has information on whom to contact. The first person is me, and I have included some of the medical doctors at Justinian Hospital who are involved in the study. We have also included Sr. Rosemary who know about the study and can respond to your questions.

Signature

_____ has been informed of the nature and purpose of the procedures described above including any risks involved in its performance. She has been given time to ask any questions and these questions have been answered to the best of the investigator's ability. A signed copy of this consent form will be made available to the subject.

_____

Investigator's Signature Date

I have been informed about this research study, its possible benefits, risks, and discomforts. I hereby agree to take part in this research as a subject. I recognize that I am free to withdraw this consent and quit this project at any time, and that doing so will not cause me any penalty or loss of benefits that I would otherwise be entitled to enjoy.

I agree to having the discussion tape recorded. ____(Initial)

_____

Subject's Signature Date

_____

You are invited to attend a group discussion at the Centre Nutrition Sacre Coeur on:

_____, _____ 2005

at

___:____am/pm

Refreshments will be served.

You are invited to attend a group discussion at the Centre Nutrition Sacre Coeur on:

_____, _____ 2005

at

___:____am/pm

Refreshments will be served.

You are invited to attend a group discussion at the Centre Nutrition Sacre Coeur on:

_____, _____ 2005

at

___:____am/pm

Refreshments will be served.

You are invited to attend a group discussion at the Centre Nutrition Sacre Coeur on:

_____, _____ 2005

at

___:____am/pm

Refreshments will be served.

You are invited to attend a group discussion at the Centre Nutrition Sacre Coeur on:

_____, _____ 2005

at

___:____am/pm

Refreshments will be served.

If you have any questions about the study, please contact any of the following:

MaryAnn Dakkak
Women’s Health, Konbit Sante
509-432-0217

Dr. Cyril Leconte
Chief of ObGyn, Justinian Hospital
509-262-0512

Sr. Rosemary
509-431-6966

Dr. Jasmin
MSPP
509-262-1261

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If you have any questions about the study, please contact any of the following:

MaryAnn Dakkak
Women’s Health, Konbit Sante
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Dr. Cyril Leconte
Chief of ObGyn, Justinian Hospital
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FOCUS GROUP FACILITATOR'S GUIDE

REMINDER TO FACILITATORS[1]

- Welcome participants and introduce yourself and the note taker. Thank everyone for coming.
- Explain the purpose and procedures of the group.

Example: The purpose of our meeting is to examine use of reproductive health services in Cap Haitien, particularly services related to preventing unintended pregnancies. We need your help to learn more about the issues that affect the choices women make about use of services. We want to learn about the different kinds of services that are available and what you think about the quality and safety of these services. The information we obtain will hopefully help to develop policies and programs that can benefit you all and the country in general.

Explain purpose of note taker; confidentiality.
Inform participants that in order not to miss any of their important ideas, the discussion will be recorded. Ensure that there are no objections to recording the discussion and note taking. Emphasize that all comments will be kept confidential. Emphasize the need for participants to respect one another's privacy.

Introduction
We will start by introducing ourselves (first names are adequate). To start with, I am …… (facilitator to introduce herself). Allow all participants to introduce themselves before you introduce the note taker.

Introduce Ground Rules

- That everyone's opinions and ideas are important
- There are no right or wrong answers
- All comments, negative and positive, are welcome
- Participants should feel free to disagree with one another. "We would like to have many points of view"
- Please speak one at a time
- Please do not discuss any personal experiences with induced abortion—either your experience or the experience of others
- Please do not share any thing that is discussed in the group with other people

[1] Introductory text based on focus group guides used for a study about access to private health care services in Greater Cap Haitien [Obuobi, 1999 #124].