In memory of Junior Lamour and his dreams and visions, who died while walking towards his goals.

“A dream is a dream as long as you don’t believe. As soon as you start believing it’s a goal to reach.” Edwin Luc Ceïde, co-founder of Prosjekt Haiti

Innovative Proposals for Primary Health Care Access in Poor Urban Areas of Developing Countries: experiences from Delmas, Port au Prince, Haiti

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ABSTRACT
The inhabitants of poor neighborhoods of Delmas in Haiti’s capital Port au Prince, are among the many people in the world suffering from crucially limited primary health care access. In the wake of both natural and human-made catastrophes, local NGOs as the Haitian-Norwegian organization Prosjekt Haiti (Project Haiti) and the local health care initiative Sante pour Tous (Health for All) attempt to navigate to stake out strategies for a collaboration to improve primary health care access, also for the poor strata of Delmas’ population. The researcher has known the target area through volunteer work since 2007, furthermore, since 2012 conducted research concerning health and well-being among the local, destitute population of Delmas. This report aims to assist the intentions of Prosjekt Haiti and Sante pour Tous through offering potentially innovative proposals for these two NGOs primary health care collaboration. Through a critical ethnographic approach the report will draw on information gained by means of field work, focus group discussions with local people, and interviews with health workers and resource persons, the report shall discuss barriers and proposals for solutions evolving the research theme. The results show actual disparities between envisioned delivery and perceived access. Phenomena of ‘structural violence’ are found to be the core of the unhealthy conditions encountered at the site. As a consequence the local population lacked faith in improvements both from the public sector and themselves putting together. Potential for positive change was seen through local NGO’s initiatives and private investors, in addition to guarding happiness and local traditions. The conclusion reaches lists of proposals to the work of the two NGOs’ primary health care collaboration, the main point given being involvement of local population on all levels. The implementation of community health care workers is underlined as essential, in addition to nurturing communication with local authorities.

Acronyms
PH – Prosjekt Haiti/Project Haiti/Pwojét Ayïti
SpT – Sante pour Tous
WHO – World Health Organization
PAHO – Pan-American Health Organization

INTRODUCTION
“Sometimes we go to the hospital and we don’t get the help we need. We know they have found the cure, so we shouldn’t die, but often we die because we lack the money” (35 year old man, husband and father of four, living in one of the slums in Delmas, Port au Prince, Haiti).

In the developing world, better termed the “majority world”, health indices speaks of a lack of well-delivered primary health care. In countries where primary health care is well established, primarily Western (or minority) countries, the primary health care-model was conceptualized to suit society and accord with local contexts and infrastructure. These models have later been applied to societies where they have shown not to fit in. This has engendered the question
whether more locally anchored and adapted concepts should be supported with appropriate recourses (1). This question seems utmost relevant with regard to societies lacking both the necessary infrastructure and economy upon which the Western model rests. Fitting into most descriptions of such dysfunctional health care systems, you find Haiti, the most impoverished nation of the Caribbean, lately most known for the devastating 2010 earthquake.

I have been engaged in solidarity work in Delmas, an area of Haiti’s capital Port au Prince, since 2007, associated to the Haitian-Norwegian NGO Prosjekt Haiti (Prosject Haiti), or in the local language, Pwojét Ayïti. By 2012, this engagement had turned into a research project connected to my medical training as well as to my attendance in the Medical Student Research Program at the University of Tromsø, Norway’s Arctic University. Resulting from repeated visits to Delmas, and ultimately while conducting a research project on Violence and Distress Prevention, I became aware that I needed to familiarize myself with the primary health care currently available for the deprived local population in Delmas.

Discussing the themes of health, well-being and access to health facilities with local people, both in everyday life and in focus groups, has provided me an insight into profound insufficiencies to the system meant to serve them. From visiting or reading about other deprived groups of people in the world, I know there is well established knowledge, both academically and through direct work experiences on improving health care access under similar conditions to Delmas. Inside the nation borders of Haiti itself, there is solid documentation concerning primary health care facilities in rural parts of the country, thanks to the work of Partners in Health (an organization I will get back to in the further of this theses), although these do not directly comply with the urban contexts I came to encounter.

In October 2014 Pwojét Ayïti lost one of its dear, young participants, and my own beloved extra little brother, when Junior Lamour was hit by a car while walking peacefully on the sidewalk to reach his up-coming drum lesson. I sat safely in Norway during the following events, knowing that improved accident prevention work probably could have saved Junior’s life; knowing that he might have survived if a more efficient health care infrastructure had been available; knowing that his friends could have become less traumatized if provided more knowledge concerning first aid. This is neither the first nor last time my friends in Haiti is struck by provokingly unnecessary suffers and deaths because of the insufficiency of the health care available to them. From my position, it therefore feels utmost important to perform this report and try my best to contribute to the paramount mission of helping my local collaborators providing appropriate health care, also for the poor and most vulnerable population of Delmas.

Pwojét Ayïti’s work on health care builds on a collaboration with the ideological and locally anchored health care provider Sante pour Tous. Both organizations seek to enhance well-being and health among their members, and are now looking into opportunities for strengthening their interventions through a tighter partnership. With my background, both in terms of longevity of my engagement with Pwojét Ayïti and my competency from previous studies, I was invited by the organizations to contribute to their collaboration with my research material. After thorough evaluation of the potential of my material, I landed on trying to answer the research question: How can Pwojét Ayïti and Sante pour Tous collaborate to maneuver between the local voices and needs and international guidelines to provide better access to primary health care among the destitute populations of Delmas, Port au Prince, Haiti?
BACKGROUND

The life by the ‘Ravin’

The roosters are cock-a-doodle-dooing. It is 0530 a.m. and the pigs are already up, feasting by the borders of the Ravin, one of several rivers of sewage floating from up-town Port au Prince houses down the valleys of poverty, in lack of underground sewers. Out of the entrance to a house only shielded by a sun-bleached, pink cotton fabric peaks Fabiér, a 4-year-old boy, eager to start his day. As more than a fifth of his fellow under-five-years-old Haitians, he’s severely stunted (2). He feels the hunger, but he knows he won’t get any food until lunchtime. Maybe.

Fabiér is the youngest son of 35 years old Mirlande’s seven children. As many poor families in Delmas, they reside on the side of the Ravin. During the rainy season from April through October, the Ravin rises and heavy rainfall often floods Mirlande’s tiny shack house, filling it with sewage and debris. She worries about the rainy nights to come, leaving her sleepless with anxiety that the house will collapse one day.

Her children are between four and 18 years of age, and not all of them have the same father. As soon as Mirlande got pregnant with her first-born, outside of marriage at the age of 16, she became unattractive as a wife. Now, she is the single breadwinner for her seven children by means of selling candy from a basket on the streets. Besides, she takes classes in order to learn how to read, write and calculate, and she hopes to soon become a member in one of Pwojét Ayïti’s micro businesses, allowing for her income to become more steady. At present,, after having payed the rent for the house and the school-fees for all her school-aged children, her money allows for one meal of rice and beans on most days.

Mirlande lives her life hand-to-mouth, her resources limiting her to a life on the edge of existence, only one unforeseen cost away from leaving her fragile economy living her and her children’s lives in ruins. She has some sort of safety net in her social capital of a few friends, family, her church, and the local NGO, Pwojét Ayïti. But there is one thing especially, that worries Mirlande when trying to sleep, all tangled up between her children’s skinny legs and arms: what if one of them gets sick?

Haitian panorama of diseases

Reports from the World Health Organisation (WHO), based on Haiti’s national statistics, reflect a society of 10.3 million people, many of these suffering from severe malnutrition, high mortality rates, and a high occurrence of communicable and non-communicable diseases. The average life expectancy is 62 years, and the mean age of the population is 22 years. The present health care system counts 0,25 physician per 1000 inhabitants, most of whom practice in the big cities, leaving less accessible areas completely uncovered by health personnel. The governmental health care expenditures are US$ 84 per capita (2-4). Compared to the neighboring country Dominican Republic, expending US$ 315 per capita, and their other neighboring country, Cuba, who has health outcomes in the same levels as developed countries, spending US$ 405 (4), it is easy to see
that Haiti, lowest on the list of health care coverage in the Americas, is facing immense challenges to reach the goal of “health for all”.

Not far from Mirlande’s block of shack houses lives Bernadette. She is a skinny, smiling woman and single mother of two daughters. The eldest, Marie Danielle, 10 years old, is almost blind due to malnutrition and lack of vitamin A during her first life years. The youngest, Izabelle at 4 years, is underdeveloped and looks like a 2 years old, suffering from both mental and physical difficulties. A doctor who attended her, explained that she probably was malnourished during both pregnancy and her first years of life. While Mirlande’s son Fabier is stunted, Izabelle is wasted. The total amount of malnourished and underweight children among Haitians below 5 years of age is 35 %. In addition, 15% of Haitian women are underweight (2).

A person living in the same area as Mirlande and her family told me how his uncle, Jean Babtiste, at 56 suddenly got a growing belly and short breath, “it was huge, like he was pregnant, but filled with water, and then one day he just died”. His uncle had not had time to go to the doctor, but the local medicine man and voodoo priest had told him it was his old worries catching up with him. If he had seen a doctor, and if that doctor had had sufficient resources, Jean Babtiste’s abdominal symptoms might have been recognized as ascites caused by liver cirrhosis or heart failure and he could have been treated appropriately.

The stories of Mirlande and her neighbors, Jean Babtiste and Bernadette, reflect the panorama of diseases taking most lives Haiti, leaving the country with a small fraction of 7 % getting older than 60 years of age. Infections like Malaria, Tuberculosis and HIV are still highly prevalent in the population. In addition, cholera was imported to the country by UN troops responding to the 2010 earthquake, ravaging the already exhausted population ever since and having caused near 9000 people’s deaths and contaminating 750 000 persons. Neglected tropical diseases like Lymphatic Filariasis, Dengue Fever and different types of helminths are also endemic in the country (5).
Figure 1, a table of WHO’s death rate statistics for Haiti, shows the proportions of infectious diseases and other communicable diseases, while maternal, perinatal and nutritional conditions take a few more lives than non-communicable diseases like cardiovascular diseases and diabetes counts. In total, the statistics show that 71% of death causes are within reach of basic prevention and treatment. To these add cases of injuries, cancers and chronic respiratory diseases, a large proportion of which probably also could be prevented.

National health profiles such as presented for Haiti, with high rates of preventable diseases, is typical for developing countries with low expenditures on health. What is also seen, independent of what country you inhabit, is a clustering of diseases among the most vulnerable, poor populations, both because of a higher probability for exposure to pathogens and a biologically higher susceptibility to get sick from such pathogens (1). Albeit all these depressing documentations, recent Haitian health statistics show a significant progress, and considerable efforts are made to maintain the positive tendency (2).

Progression in Haitian national health care delivery

The 2010-earthquake left only 11 out of Haiti’s former 48 hospitals intact, and destroyed both key universities for medical studies and nursing schools. Although the earthquake paralyzed the national health care system, the restoration, despite being slow, has unified international and national forces. The past 5 years’ of work and expenditures are beginning to show results. Most
health indices are improving, but the crucial challenges persist. The greatest of these is that foreign investors and overseas donors are moving to other crisis-stricken areas in the world. “Although the government devoted more money to health last year, overall spending almost halved because of a 60% reduction in external support” (6, p2).

As a response to this drop in funding, an initiative has been taken to renew the national health care system through a collaboration between the Haitian Government, the UN, USAID, and other stakeholders such as local and international NGOs, academics, and civil society representatives. The aim is to “get better results with less money by improving coordination through the ministry of health” (6, p2) by enforcing taxes and public health insurances to secure a sustainable flow of money, independent of foreign aid. Nonetheless, the question is whether Haiti’s fragile government will be able to follow up these plans (6). In January 2015, the parliament was dissolved after massive protests, accusing the government for corruption and for undemocratically postponing the elections for both senate and presidency. A consensus government appointed by President Martelly is in charge until the overdue elections of senate on August 9 take place (7). As for the Minister of Health, Florence Duperval, she was firstly, respected for her progression of work, named interim Prime Minister in the short period before the consensus government was sworn in. In the consensus government she has kept her seat as Minister of Health and can continue her work on building a functional national health care system (8, 9).

The global health movement

From a global view, discussions about how to provide quality health care that reaches out to the most vulnerable have been going for decades, starting with the Alma Ata Declaration from 1987, where an international primary health care convention outlined the guidelines that have made the foundation for World Trade Organization’s (WHO) goal on achieving “Health to All” (10). Primary health care has proven to be the key to improve health indices, showing far better health outcomes in countries and states with well-established and accessible primary health care systems compared to places with more hospital centered health care systems (11). WHO supports these findings, but also recognizes the immense challenges the movement is facing, spending their whole 2008 World Health Report with the title; “Primary health care – now more than ever” (12).

There is international agreement that both access and delivery of primary health care in countries like Haiti, with the immense burdens of historical, political, social and natural disasters exhausting both its people and the country’s health care structure, needs to be conceptualized differently from the prevailing models in Western countries. Nevertheless, one regularly observes that situations characterized by great demand yet little supply, interventions all too often are “designed in an ad-hoc manner to address one health problem among many; they are too rarely assessed; best practice spread slowly” (13, p1).

One of the strongest voices for renewed thinking around global health matters is Dr Paul Farmer, whom also started his career and mission of providing health care to the world’s most vulnerable in the Central Plateau of Haiti. Farmer and his colleagues therefore call for a “redefining of global health-care delivery” (13, p1). They argue that much of the problem lies in the absence of
continuous and robust research on outcomes of nationwide health care initiatives in developing countries. This goes especially for countries ranged high on corruption indexes (13). Supporting the protesters against the 2014 Haitian government, Transparency International rates Haiti the most corrupt nation in the Americas and among the far lowest ranked worldwide (14). Along with the crucial task of combatting corruption, the professors underline the importance of an approach based on rights, arguing with legal matters for “health as a human right” (15, p7).

Taking on this right-based approach, they lean on the world-wide definition of health: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (10, p1). Furthermore, there is the Universal Declaration of Human Rights stating that: “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services” (16, Article 25.1)

During own interventions, global health workers experience that operating in a foreign field while trying to provide the best possible public health care despite limited time, bad infrastructure and corruption, leaves them in limbo. Ought they keep to the proximal, clinic-based work they know so well from the western models or rather invest in more extended and distal interventions, moving out to the communities and local governments to identify the real sources for illness? Yet, the fact is that “there is little compelling evidence that we must make such either/or choices: distal and proximal interventions are complementary, not competing” (17, p1689). And as Farmer puts it “Without an equity plan to bring these tools to bear on the health problems of the destitute, these debates will continue to waste precious time” (17, p1689). Providing better access to all effective strategies and tools available in current medical practice, or comparable innovative alternatives to these, also for the vulnerable in poor nations, is the only way forward, and the main focus to fight unnecessary illness and suffering should be on providing quality based and accessible primary health care to all.

Local collaborators’ frameworks for interaction in the primary health care sector

In the midst of local voices and national and international guidelines and movements, my main local collaborators are trying to develop and strengthen their interventions. This is not an easy job, especially not when every hour is filled with hands-on, day-to-day challenges. Among their clients and students the staff members observe the urgent need for health care and the lack of access to already existing yet inappropriate health care facilities and interventions. As a result, Pwojét Ayïti (PH) cooperates with another local NGO called Sante pour Tous (SpT), assisting me as a second local collaborator in this project. Both NGOs aim at improving their work on health issues for the population of Delmas, separately and together.

PH ground their work in education and run two primary schools, one in rural Haiti and the other one in Delmas 33, a close suburb to the capitol, Port au Prince. Aiming at improving the well-being of their pupils’ whole families, youth clubs and women’s networks have been instituted. In addition to their daily activities, all members of these services receive information about different issues in order to prevent illness and promote well-being, such as nutrition, sanitation, protection against specific infectious diseases, STDs, and family planning. PH’s educational principles are informed by assistance to local people to take responsibility themselves. Their well-established
and close contact to the local community offers a great opportunity to reach out to the impoverished population of Delmas.

Figure 2

Members of PH’s women’s network, Manman Troll, on their graduation day after three years of vocational training (18)

Sporadically PH has offered direct health interventions. Examples are that visiting Norwegian doctors have been running an improvised out-clinic for tent camp refugees after the 2010 earthquake. The doctors saw the need for a permanent health facility at PH’s establishment, but there has been a lack of facilities. Another health initiative was a close collaboration with Norwegian midwives. This intervention aimed at establishing a training program for community midwives by means of teaching locally practicing traditional matrons (birth helpers) basic midwife skills, as for example being attentive to early indicators to birth complications to encouraging pregnant women to seek professional help in time, and thereby reducing the high number of maternal and neonatal deaths. The project was disrupted by the earthquake. Yet the need has remained.

Sante pour Tous (Health for All), named after the slogan of the Alma Ata Declaration from 1978, runs a clinic some 15 minutes driving away from PH’s urban primary school, and is also basing
its work on primary schools. The founder, Dr. Charlemagne Woolley, grew up in this area, witnessing the piercing every-day misery in the streets. After his graduation from the medical school he worked for abolishing the systematic exclusion from health care of those in deepest misery and need. In other words, Dr. Woolley is already familiar with the concepts of searching local innovative solutions for improvements of health care delivery. His final concept is similar to an insurance, providing health care to an affordable price, also for Delmas’ poor population. The model includes local schoolchildren and their families in a prepaid health care program, providing the participants something similar to a health insurance, for US$ 12 per family per year. If the school can enroll enough families, SpT provides a school nurse who monitors the pupils in return (19).

Dr. Woolley explains it in one of our meetings: “The nurse is looking after the children, and if a child has a problem that could be contagious, or maybe broke an arm, the nurse sends the child over here, so that we can treat it. We also send a doctor to the school once a week or every two weeks, to do routine checks of the children. Like this we progressively get through the list and every child is seen three times a year, once a trimester”. In addition, SpT offers lectures on sanitation, nutrition, sexual education and family planning to staff, the students and their parents.

The pre-payment model is in line with the suggestions from WHO, stating that “Pre-payment systems must be nurtured now, discouraging direct levies on the sick and encouraging pooling of resources” (20, p106). However, the fact that SpT is private and based on a business model, limits them in the work of reaching also the most deprived. On the other hand, PH somehow fills the gap by providing care regardless of people’s ability to pay. They have some fees, but if you cannot pay, there are systems to cover the expenses. PH, on the other hand, has limited capacity. Located in a quite small house on a fairly small compound, combined with a mission to contribute to various aspects of the members’ lives, represent restrictions with regard to the number of people acceptable for this organization. PH is also an international NGO, economically dependent on foreign funders which restricts flexibility and continuity. SpT, on the other hand, is independent from donors and can base its efforts on a sustainable budget.

Although both organizations have limitations, their strength is their solid local anchoring. Both projects have Haitian owners and local staff and advisors. In addition, both groups are eager to contribute to a positive development. Their networks stretch from people in deep poverty to powerful politicians. This position provides the two organizations together with a unique insight to all levels of society. Ingvill Konradsen Ceïde, co-founder and leader on the Norwegian side of PH reports:

“Health service in Haiti is not free, and thus not an option for the poorer segment of the population. The collaboration with Sante Pour Tous will assure easier access to a professional medical team and clinic. Also information and knowledge regarding health issues is distributed via the Sante Pour Tous collaboration. In the women’s network, Manman Troll, we have seen over the years that when women come together in a safe setting, access to health service becomes a natural part of their discussion and worries. Empowering our local women will hopefully lead to more involvement in local politics and bring positive changes in the community”.

My own position again, is to seek and reach proposals on how to better deliver primary health care in Delmas, also to the most vulnerable persons, through uniting the frameworks of PH and
SpT. What wishes and advice do the participants from the local, population present through my research material? How do the health workers connected to the organizations view the topic? How well does the public, state funded primary health care serve the most vulnerable parts of the local population? What insufficiencies in the public health care must, at this time being, be filled by NGOs? Lastly, what does literature say about comparable issues – are there relevant experiences from other, similar parts of the world?

**Working progress**

The work for this thesis is done in cooperation with the leaders of my two Haitian collaborating NGOs and my academic supervisors from UiT. The planning of the thesis started already in 2013, with a final project description ready in the spring of 2014. Since my two local collaborators had a wish for what they wanted me to research for them, I have stuck quite strictly to the plan ruled out in 2014. The schedule for the project has through had to take a few unforeseen turns, both from Haitian political unrest and severe illness in my own close family. Being flexible is a part of researching, and the meetings with Haitian collaborators first scheduled for August 2014, were held in December 2014, and the weeks of intensive analysis and writing got a bit more crammed during the spring of 2015.

Although, the program has been approximately identical to what was scheduled in the project description: one week to meet and plan together with Haitian collaborators; five weeks literature study, four weeks of analysis and four weeks of writing. In addition to the work done prior to the final project description, which includes both the work of gathering the major part of my material through my engagement at the Medical Student Research Programme, but also the reorganization of this material as a part of the process to develop the final project plan for this thesis.

Due to the extensiveness of the full material for this thesis, a planned narrative literature review, was removed from the method part of my work, and rather used as literature for the discussion section. With tight mentorship and good support from my supervisors, the process of writing this report has been both educational and inspiring. I now hope my collaborators will be pleased and find a use for my findings.

**ETHICAL CONSIDERATIONS**

“The ultimate responsibility of research is to seek the truth, and to require interesting and relevant research issues, verifiable documentation, impartial discussion of conflicting opinions, and insight into one’s own fallibility” (21, p8).

To sum up the content of the background section, the wellbeing of the participants is challenged by seriously threatening life conditions. Since I myself am born and raised in stable, democratic Norway, I am not experienced in such realities. How can I possibly know ways to see and name some true findings despite such culture differences?
When having delineated my own presuppositions, I acknowledged the fundamental premise for my research to be a sound ethical basis. My intention was not only to understand people who are socialized in a different culture. I also knew I would encounter vulnerable, deprived persons, a situation that calls upon particular ethical concern (22). The fact that I am a white, educated person with relatively rich resources adds to the power inequalities between the participants in my study and myself as a researcher. Since I aimed at exploring sensitive topics such as health, wellbeing, personal problems and illness in order to eventually be able to contribute to a change, ethical considerations became even more important (22, 23).

My project, aiming at identifying core problems linked to health care in the area and eventually propose innovative changes by means of listening to the local people was strongly supported by Pwojét Ayiti. Sharing my intentions and trusting me, they helped me find volunteering persons for study groups among their users, also called members.

**Ethical advisors and continuous communication**

Throughout my whole research period, I searched ethical advice from a group of five or six of Pwojét Ayiti’s staff and stakeholders. These persons guided all steps in my work, especially during phases when I planned interventions involving local people. Continuous communication with the local collaborators PH and SpT was prioritized throughout. Meetings were held either with both of them simultaneously, or with Sante pour Tous’s co-founder and myself only. I had numerous dialogues and meetings with Pwojét Ayiti’s stakeholders as I shared office with their staff). I also made a one-week visit to Delmas in December 2014, in order to meet with my local collaborators and discuss further aims for our teamwork.

For both these organizations I am an outsider, asking for permission and help to perform research with the frame of their facilities. They and the study participants offer time and energy to provide me study material. This implies an obligation to accept their premises, cautiously adhere to their schedule and not intervene with their everyday work. With their offers in mind, I will hopefully be able to give something back to them when my study is terminated.

**Giving something back**

One of Haiti’s greatest challenges is inherent in the current foreign involvement, and, linked to these, a high risk of causing “unintended consequences of purposive (or social) action” (24, p1518). Haiti, the poorest country in the western hemisphere and in many ways closely related to USA, strives with immense social and political problems. The country has for many decades been among those with the highest density of international Non-Governmental Organizations (NGOs). After the earthquake Haiti was nicknamed “the Republic of NGOs”, referring to the disbursement of NGOs, jeopardizing the power of coordinated aid efforts. The local people themselves joke about the earthquake as the “Gwó machin ki pasé”, or “the big truck that went by”, referring both to the perception of the earth trembling when big trucks pass by, but also to the massive amount of aid workers entering the country (by the local population only observed as big trucks driving pass them) and suddenly disappearing, seemingly leaving little gain for the local impoverished population (25).
Asking people who live from hand to mouth to spend quite a few hours answering my questions, engenders the obligation to give something in return; to fulfill the work, and to make their voices be heard. The same obligation applies towards my local collaborators who spent their time to support my interests.

**Precautions taken**

Openness and tight cooperation with especially *Pwojét Ayïti* were my main means. Each person participating in focus group discussions was informed about the aim of the study and assured the utmost importance of their knowledge and voice in the effort of eventually reconceptualizing *Pwojét Ayïti* and *Sante pour Tous*’ strategies for improved access to primary health care for their members. A generally humble approach from planning the fieldwork to finalizing the analysis was essential for making sure that the informants understood the significance of their contribution to this work and to prohibit my own prejudices to bias the study results.

Of ethical reasons, we invited all members of *Pwojét Ayïti* according to their age to meet their peers in groups for information with the staff of *Pwojet Ayïti* present. Potential participants were encouraged to ask questions and to delineate the most urgent issues concerning certain topics. When attending the first focus group, they initially were asked to sign a consent form. In every focus group meeting thereafter, they were reminded of their right to refuse to answer particular questions or to withdraw from the project. In addition, they were assured strict anonymity and were told to keep personal stories, shared and heard within the group, to themselves. Furthermore, they were provided a meal after each group meeting as a token of gratitude for supporting the project, as time spent with us reduced their daily income. When the fieldwork was terminated, every participant received an attestation of his or her contributions to the project.

The Regional Ethical Committee has approved the present study (approval attached).

**METHODS**

The topic of this report emerged while I performed a research project on violence and distress prevention in the area of Delmas, Port au Prince, Haiti in 2012-2013, after having been enrolled in the Medical Student Research Program. Within the frame of that work, access to health care was extensively discussed quite in focus groups including local deprived people of both sexes aged 16 to 50 years. This report is based on parts of the material, providing insight into either threatening or promoting components for health and health care access and delivery. In addition, material providing proposals to health care workers and other providers of help, such as international and national NGOs, has been utilized.

A focus group approach was primarily chosen for ethical reasons since doing research among vulnerable people can be jeopardized by the asymmetry of power between researcher and informants. Using focus groups reduces this power imbalance, allowing discussions in the mother tongue of the informants, a prerequisite for understanding their lifeworld (22). In addition, focus groups generate data which provide an insight into social contexts linked to the actual topic,
engendering associations which may deepen the discussions about aspects that otherwise would have remained unspoken (22, 23).

In addition, I applied an ethnographic approach during my three-months’ stay in Delmas in 2012, resulting in relevant field notes from everyday life, interviews, and meetings with resource persons, and a placement at the local public hospital. In applying a critical ethnographic approach, I seek to advocate the need for a change in health care delivery on behalf of the local, deprived participants. Or, as John W. Creswell puts it: “address an inequity in society or some part of it, and use the research to advocate and call for changes” (26, p95).

Adding critical to ethnography has been a natural choice for many researchers seeking possibilities to change the existent, especially in realms of post-colonialism and despair, while exploring foreign cultures. I feel inspired by the theories of critical theory presented by D. Soyini Madison, who, inspired by French historian Michel Foucault, states: “Critique occurs when a subject gives itself the right to question truth as truth operates through power and to question power as it operates through truth” (27, p16). Madison also relates critical ethnography to the reflexive theories of French sociologist Pierre Bourdieu concerning ‘habitus’, when stating that our world views are “culturally learned modes of being, thinking, value, and behavior that derive from deeply positioned home-placed worlds that we inhabit with others” (27, p9). This nexus implies an obligation to turn critical thinking back on ourselves and our intention and ethical responsibilities (27).

It is my explicit wish to use an ethnographic approach in the sense of James Spradley, who says: “to document the existence of alternative realities and to describe these realities in their own terms. Thus, it can provide a corrective for theories that arise in Western social science” (28, p93). Through the lens of critical ethnography, I hope to identify some of the controversies between the local health care providers and their target population, and the main incompatibilities between deprived urban contexts in a developing country and the norm of health care systems developed to fit the “West”.

**Fieldnotes**

During my stay, I wrote field notes about situations concerning the topic that had occurred during the day, along with describing certain conditions in an online blog (29). The notes also comprised relevant personal conversation. These notes are reviewed for identifying relevant issues for further interpretation in this report.

**Focus groups**

One introduction meeting and six focus group meetings were held with participants from local destitute populations living in the area were both collaborators are located. The introductory meeting was open for all members of Pwojét Ayiti, females and males, informing them of the purpose of the research and the conditions for participation. Those who wanted to join signed consent forms when showing up at their first focus group meeting.

The 6 focus group meetings, designed according to Malterud (23), included 22 participants, 18
women and 4 men, and were divided in three groups: women aged 25 to 35 years; women aged 35 to 50 years, and men aged 25 to 40 years. Each group met twice. Most participants attended twice, but a few only once.

The discussions were directly translated from English to Kreyol. The translator had been introduced to the actual topic, the overall aims of the study, and to a summary of the meeting details. Each focus group discussion was audio-tape recorded and transcribed. One of the recordings was lost due to technical problems yet reported in notes I took myself during and after the meeting.

Meetings and interviews with resource persons

Semi-structured interviews and meetings were performed with resource persons, including Prosjekt Haiti’s two connected nurses, and their nurse student, in addition to a physician, the co-founder and leader of Sante pour Tous. Whenever a conversation could not be performed in either English or simple Kreyol, a translator was present during the interviews. All these meetings and interviews were audio-tape recorded and transcribed.

Analysis

The analysis of the material has been performed according to Malterud’s approach which leans on Giorgi’s analytic methods, aiming at insight into the informants’ experiences and lifeworld (30). I also draw on Lindseth and Norberg’s adaptation to Paul Ricoeur’s phenomenological hermeneutical analysis of narratives and lived experience (31).

In the first analytical step, I read all the transcripts and noted eight themes that were central to all of them. The second step consisted of coding particular topics in the data program Evernote: “health care access”, “health care delivery”, and “health and wellbeing”, aiming at identifying all the material that addressed these core perspectives of the current research question. In the third phase, meaning units were extracted, thereafter differentiated into subthemes, themes and main themes. Next, the main themes identified under each code were described and explained in written text, whereupon and the original text was revisited, both for a to check as to correct identification, and for marking statements for quotation. This evaluation resulted in renaming in the sense of ‘recontextualisation’, informing my final written analysis (23, 30, 31).

The ethnographic reports were evaluated, two years after the conducted fieldwork by means of directly extracted subthemes, a shortcut facilitated by my profound familiarity with their content. Combining methods as described above, has enabled me to formulate some tentative answers to my research question

RESULTS

Throughout this section of my report, I will present findings from focus group discussions, interviews and ethnographic fieldwork. I will let Mirlande’s story open the chapter, and close it with a conceptual analysis of the local challenges to public health.
Ethnography – deeper into the life by the Ravin

To present the backdrop of my participants’ lives, I will go back to the life by the Ravin, the everyday scenery endured by many of the people targeted by my two local collaborators. Mirlande starts and ends her days inside her little eight square meter shack house, hoping for a better future – especially for her children. For an outsider there are health threats identified immediately when visiting her neighborhood. There is lack of sanitation, with only an agreement among neighbors of a shared area as toilet. There is the sewage river itself, and the lack of space, leaving most kitchens to a few pots, surrounded by flies and resting on the dusty ground. Clean water is either bought or collected from the few far-away wells disbursed by international NGOs. The growing collection of debris and sewage rises the collection of pathogens to an even higher burden on the dense population. Few people have shoes to protect them from infectious cuts from the many disbursed sharp subjects of garbage. Although energy can still be high, with smiles greeting you on most corners; smiles do not hide exhausted eyes and worn out clothing, neither do they hide the malnourishment of children, the many skin diseases and the physical scars.

I meet Mirlande through our focus group meetings, whenever she’s doing her classes through Manman Troll (Prosjekt Haiti’s school for women), and also quite often while walking the streets of our shared extended neighborhood. While speaking to me of her troubles and worries, Mirlande lifts her head in a proud way, and raises her voice:

“I work really hard, but most of the time I can’t feed them. Their fathers don’t give anything for the kids. I’m the only provider. They are almost finished in school, but I don’t have money to send my kids to university. They won’t get a work because they are unskilled for professions”.

Tears come to her eyes when mentioning her children and the lack of food and money for further education. But she controls her emotions, and when continuing her tears are gone. I have seen this phenomenon often among Haitians. Although deeply aware of their tragic situation, they suppress their sadness and take pride in who they are and what they manage with the little they dispose. She continues:

“The streets are hard, we don’t have money, we have stress from that, our children can’t go to school, everything is expensive, and of course, if you’re sick, you have a problem finding medication. So it’s like where ever you turn, you can’t relax.”

I have visited the areas where these women live. It is no place for mental tenderness. I have also walked the streets where they are selling, and not only is the atmosphere often aggressive and hostile, but the dust which is blown up by the big passing cars of either rich neighbors or international aid workers pollutes the air to a degree that is far from healthy.

In a focus group meeting with seven other 35-50 years old women from different poor areas around the middle of Delmas, I ask a question on how the health care system works for them. Mirlande stands up, telling the following: “What I’m most afraid of is falling ill. I know that I can’t afford the treatment if I fall really ill. So if I fall ill, I will die, I believe. (…) My greatest fear of all is if a family member gets sick during nighttime. Because at that time you can be pretty
sure that you can’t find any health service. For example, the [Public Hospital], if you go there during the night, you are probably not going to find anyone to help you. That’s a big problem.”

Another woman fills in on the problems with health care access of the area: “We don’t have the money to go to the doctor and sometimes it even takes the whole day to go see the doctor. Actually, if you have a sick child, you can sometimes use a week trying to see the doctor. One of the things that makes it complicated is that even if you get to see the doctor, he will make you come back or go somewhere else to do the tests. So, you spend days and days going back and forth, it’s not done quickly.”

Mirlande, standing steady and strong and with her arms straight down and her head lifted, tells a similar story: “I came to the hospital very early one day with my sick child. I stayed a long time there to be able to see the doctor. This is because, if a patient knows the doctor, or knows the nurses, they will go before me. I sit there the whole day with my sick child, and I’m not able to encounter the doctor because someone is always getting in before me, and my child is getting more and more sick between my own hands. You don’t have money for food, you’re hungry and it’s a misery.”

Not only is the child getting sicker, but a whole working day’s income is lost while waiting for an appointment. I have, through a short placement at the local public hospital, witnessed these chaotic lines. At 2 p.m. the doctors left and the nurses sent a third of the line home— or to another line, another place in the city, if the patients said it was urgent.

Mirlande continues her story: “Finally, because a neighbor of me working there finally saw me, after I’d been sitting there the whole day; they asked: -what are you still doing here? Finally, I was able to see the doctor and I got a prescription for medication for the child. I was lucky because of my friend who worked there and was able to help me, because when the child got the medication the fever finally came down.”

Using their own experience as an argument in a discussion is a common trait in Haitian discourse culture. If somebody asks how something works, people will reply by saying “Map ba ou yon istwa” (I give you a story). When the story is finished, the listener is left to answer the question her/himself. Already having trouble fully comprehend the story Mirlande had given me, I learnt from her stakeholders at Prosjekt Haiti that Mirlande already had lost one child to an unknown infectious disease, there is no doubt that her stories leave me and my local collaborators with a responsibility to respond to a desperate need for renewing the local primary health care system.

Challenges - as presented by the local population

**Barriers to access health care as seen by local people in focus groups**

“If you don’t have money you won’t have access to health care” (28-year-old man in focus group).

Through focus group discussions, the participants identified main obstacles for them to access health care in their area, evolving from questions on the problems surrounding the existing health
care given in the area. Condensing the main points made in the discussions, I present a list of eight barriers identified by the focus group participants (table 1).

<table>
<thead>
<tr>
<th>List of challenges made from focus group discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of money to pay for health care</td>
</tr>
<tr>
<td>You need to pay bribes or to know someone to skip the line and get the help you need in time</td>
</tr>
<tr>
<td>Long lines in waiting room</td>
</tr>
<tr>
<td>A fear of humiliation when at the hospital</td>
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<tr>
<td>Inefficient and expensive transportation</td>
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<tr>
<td>Inefficient patient health care chain from bad institutional infrastructure</td>
</tr>
<tr>
<td>Too few doctors available</td>
</tr>
<tr>
<td>No help to get during night-time</td>
</tr>
<tr>
<td>Lack of access to health information and knowledge about health</td>
</tr>
</tbody>
</table>

Most of the listings evolve around access to the health care system as it is today. There was consensus among the focus group participants that even though public health care is cheap, and sometimes even free, there is not real access to it. Either it takes too long waiting in line to see a doctor or, for different reasons given; you do not get the help you need. As one of the men said:

“We have the Public Hospital here in Delmas. It is placed there to give health care to those who don’t have the money, but this is the place where they actually humiliate you. It is here to serve you, but they don’t” (35-year-old man in focus group).

Among the challenges recognized by the local population, “lack of access to health information and knowledge about health” is the only challenge identified that involves a way for the local population to contribute to health care themselves. The other seven enlistments regard health care institutionalized within the only systems known to the local population: hospitals and clinics.

- Analyzing the enlisting further, four main themes emerged from the focus groups: Economic situation
- Institutional infrastructure
- Transportation infrastructure
- Knowledge

Views on local health care among the nurses interviewed

All the nurses I spoke to during my fieldwork perifound the main challenge to well-being and health in their local environment to be poverty. Health care access on the other hand was seen to be restrained mainly by the population’s will or knowledge to seek health care. For example a
nurse, who spent much time working out in the community, could tell that not many of the pregnant women she met went to pregnancy check-ups. Many of them also didn’t seek professional help for delivery. Knowing the local community health work well, her view was that the local women had got information about the health risks of pregnancy and knew that they should attend the free check-ups and delivery care, but “They just don’t want to do it”.

This view on the will of the local population seemed quite wide spread among health care workers. If an intervention for example had community meetings with lectures about a certain health topic, the health workers seemed to believe that the responsibility for understanding the message and taking action had been automatically transferred to their listeners.

To sum up the reflections given by the nurses, their lists of challenges to the delivery of health care were 1. Poverty, 2. The will to seek help 3. Lack of knowledge about how and why to seek help from the health care sector.

**The doctor’s perspectives**

The physician in SpT agreed with the nurses that poverty is the main limitation for the poor populations to access health care. He also agreed on the fact that there is little knowledge of health among the population. Taking this into account, he says he believes the population “needs to be guided”, but his experience tells him that there is no lack of will to seek health care, as long as there is knowledge about why it is necessary.

Following this, he enhanced the importance of health care workers’ knowledge of what diseases are out there. Dr. Woolley seemed to have a clinician’s view of the problems, spending most his time answering questions about health care challenges by referring to clinical problems. He listed the biggest health challenges of the nation to be: 1. Malnutrition, 2. Infectious diseases, and 3. Chronic diseases.

“High blood pressure is something you really must consider when working in Haiti. It is very common, and not only among big sized people. Black people have a tendency for high blood pressure, and also we are eating a lot of salt in our diet. There is also a lot of stress in our country. So, there is genetics combined with exposure to risk factors”.

The same goes for diabetes: “We have a lot of diabetes too, which can be explained by the big amount of rice in our diet. We also have a predisposition for diabetes”. Dr Woolley underlined that while both of these types of chronic diseases can be explained by genetics and stress, “the habits of our diet is the main reason” (all quotes are from an interview with Dr Woolley in 2013). By these examples, Dr Woolley explained his beliefs in possible intervention - these are treatable and preventable diseases that people die from when they could have been saved.

Analyzing the focus group discussions with local people and the meetings with Prosjekt Haiti’s nurses, there is another group of diseases to give extra attention to, namely mental illnesses. There was many comments about people having mental problems after the earthquake, and about high rates of stress in the population. There is also a tendency not to accept mental illness, both among Haiti’s population and health care workers. In personal conversations with PH’s staff it is referred to as ‘White man’s problems’ and something Haitians feel too strong suffer from.
When discussing the most common diseases in focus groups, the local people mentioned high blood pressure, flus and colds as common local illnesses. When asked what they fear the most, they replied cancer and AIDS. The diseases said to be most common to die from were high blood pressure, cancers and ‘small diseases’. If we compare these findings with both Dr. Woolley’s statements and the national statistics of diseases and deaths, there is some mismatch between the focus confirming the outspoken need for more knowledge on health issues among the local population.

Searching between the lines – further analysis of discussions, meetings and interview

Trying to understand the challenges of the living in Delmas, Port au Prince, I soon learnt that much of what stands clear to me as violation of people’s right to health and well-being, was normalized as “that’s just the way it is” by my participants – including the health care workers. This points to the necessity to look behind the most obvious obstacles to health and well-being to enable a deeper understanding of hidden challenges to the delivery of health care that reaches out to the population.

The violent structures

I would like to extend the analysis of my material by presenting what I find to be the most complex challenge to health care for the most vulnerable population of Delmas: Structural violence. Structural violence was termed by Johan Galtung already in 1969, as an “avoidable impairment of fundamental human needs or (...) the impairment of human life, which lowers the actual degree to which someone is able to meet their needs below that which would otherwise be possible” (17, p1686)(32). Explained further by Paul Farmer, the concept involves “arrangements that are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people (typically not those responsible for perpetuating such inequalities)” (17, p1686). The term is widely used when arguing for stronger awareness to the social determinants of health.(17).

Asked about local examples of violence, my participants’ list of problems were almost endless, including the lack anything from basic human needs like clean water and sanitation, to security and freedom of speech. All of which potentially could contribute to bad health. When digging deeper into ‘why’ all their listed violations and problems were present, almost all agreed: “I want to say that, I would like to hold the government responsible for all these [violence and problems] together” (36-year-old man in focus group).

In all focus groups, there was also a notion that individuals inhabiting each neighborhood should ‘fe tét ansanm’ (put their heads together) and change things themselves. The reason for this not to happen was told to be both laziness and frustration over one’s poverty and misery. A 38-year-old man concluded one of our discussions – receiving agreeing nods from his fellow focus group participants: “There’s a lot of things the government should be doing, but don’t do. When you try to do it yourself, they try to crush you down”.

Insecurity and legal matters
“My biggest problem is the feeling of insecurity. That you can't work in the evening for example, you can't go down the streets on your own.” (30-year-old woman in focus group).

The area my participants inhabit was for some years characterized as a red zone for violence. The many tent camps emerging after the 2010 earthquake were assaulted by criminal gangs. My participants told about high rates of rape in the camps, and how their few belongings were stolen from under the tent wall. The tent camps are now moved, and the red zone warning lifted, but rates of violence are also in my study, still high.

Not only the lack of police and their help is haunting the people, but also the lack of justice; the lack of a functioning and fair law system. Participants expressed a fear of walking outside during nighttime – making health care access even harder during dark hours. There is both a fear of crime and a fear of not being heard by the court. They also believe that if matters of security and justice were in place, knowing the police would come if you called for them, knowing there would be a lawsuit for crimes, the amount of criminals threatening their health and well-being would be reduced.

Their economic situation is also negatively influenced by the threats of legal security. Informants told about robberies of all their sales items, ruining their whole business and economy. There is not only the low daily payment of their work that keeps the poor from entering insurance systems, but also the lack of trust in any kind of authority.

Distrust

As Mirlande’s story from the public hospital illustrates, your social network can mean life and death in Haiti. You need to stay friends with the right people – and not with the wrong. There is a cynical side to a nation that has built its identity on the slogan ‘Fait la force’ (Unity makes strong). There seems as if there is a fear of trusting. Looking back in both near and distant past, the tendency is highly visible. Policy makers, both national and international, including foreign aid workers, have broken too many promises and trustful relationships – especially towards the vulnerable poor and lowest social classes. As my focus group meeting with local women showed me, this distrust translates also into the health care sector: “The doctors have their own private Clinique, they don’t have the time to come to give us medication”. There is more money in the private clinic practice and among the poor population there seems to be no trust in the doctors not to leave early from the public hospital to earn more money helping the richer upper class.

Not only is their nation’s slogan Unity makes Strong, but Haiti is also proud of its strong traditions for “konbits”, a type of working party where people get together to work for their community. But it seems like these traditions are slowly dying in the overcrowded cities, crushed down by poverty and too many years of political instability.

“You’re working and you know that there are a few things that the boss should not do to you, and if he does it – he violates your rights, he just does it. So you know that if you go to court with it, the boss will win” (36 year old man in male focus group). When living in Haiti I saw and heard of many examples of this type of misuse of power. It seems like there is a notorious tendency that power corrupts – leaving a strictly followed consensus in the population of greeting any approach
with a ‘Who are you and what do you want from me?!’ Stakeholders of PH and SpT tell about how many years it has taken to gain the trust of their members and their neighborhoods.

**Corruption**

When the distrust and ‘one man for himself’ ideology become institutionalised, you soon face corruption. In Haiti it has gone so far that it seems as if the corruption piercing most of the sectors of Haitian society has contaminated a whole population. Although not listed explicitly in our meeting, corruption was nevertheless an issue, which all groups addressed, linked to both violence and other general problems. Corruption is intrinsic in everyday life; it’s just the way it is, thus not acknowledged as a hindrance to health care access.

Although corruption wasn’t recognized distinctly, it was identified as something belonging to political leaders and the upper class. It was also recognized as a burden, piercing the higher levels of social society: “A man from the upper-class won’t be able to ‘walk with himself’ for the corruption he serves. Me, who serves God, am able to ‘walk with myself’” (36-year-old man in focus group). Being able to ‘walk with oneself’ is here used as a phrase to describe a feeling of confidence and pride for who you are and what you stand for.

Political violence, spoken about in the same breaths as corruption, was recognized as belonging to politicians, while corruption itself was recognized to also include the upper class. There is no outspoken recognition of corruption within the health care sector, but comments about needing to bribe health personnel to get to see a doctor; of doctors leaving their job at the public hospital early to earn more money in their private clinic, leave little doubt that corruption pierces also this part of the Haitian society.

**Racial, class and gender inequalities**

Haiti’s social life is limited by its deeply rooted racism, still remarkably existent more than 200 years after slavery was ended. A growing type of structural division between inhabitants, termed as ‘classism’ in the daily, local discourse, also exists. Within the black population, your class distinct what amount of respect or disrespect one treats you with. Adding these unfair treatments to the profound inequities in terms of income, the social gap between rich and poor is colossal.

“They got money. beautiful cars, living in luxury, when they are passing by and there is dust, they will just drive faster. Those who are at top, if you are dealing with them, they will try to push you all the way down”.

While living in the midst of social indifferences, I have witnessed both racism and classism close-hand. Everything from unprovoked spitting on poor black skinned beggars by light skinned men in big, expensive cars, to posh upper-class people yelling harassments at low-class workers, or the most common: speaking French to oppress the majority of the people who speaks Kreyol.

Women are situated at the bottom of all social ranking systems. Haiti is a patriarchal society imposing limitations of rights and access on females. The women in my focus groups tells
numerous stories of men leaving them with too many children for their economy to carry. Adding to the discrimination, women of Haiti, especially the poor, suffer from the fear of being violated.

**Sexual and gender based violence (SGBV)**

Analyzing the influence of structural violence on public health in Haiti, SGBV needs special attention. SGBV showed it’s ugly face both in participants’ discussions and in my fieldwork. Throughout my research period, two of PH’s teenage girls have reported being raped. One of the girls was gang raped. Harassments of girls in the streets is very common, as one of the participants explained: “We are used to it, so we don’t care that much”. However, girls harassed in the streets also told about being so scared that they had to run in safety. When discussing rape, a general notion among the women was “In Haiti we have a serious problem. We say that girls are the victims of rape, but girls are sometimes provoking the guy to rape by dressing or acting a certain way” (25-year-old female nurse student in interview).

Women still hold the male rapist guilty, but there is a mentality towards accusing the girls of “you kind of asked for it”. The grown up women discussed a report they had heard in the radio:

“In this report they found that the girls that were most likely to be raped were the girls that were out there a little bit, maybe dressed a little bit liberal and out flirting. And the second category of the girls who are most likely to be raped were those that didn’t have parental control – that the parents kind of let them go, and they didn’t know where they were, they were out in the streets and the parents didn’t really take responsibility for these children. That’s what I know about this issue” (28-year-old woman in focus group).

Their conclusion was that it is the mothers’ responsibility to teach their daughters how to dress and act to prevent rape from happening. Among younger girls there was a shift towards that girls should be allowed to wear whatever they wanted – “if I want to walk naked, I should be able to!” Nevertheless, they expressed that they would never dare to not dress within the common norms. Another point was that “It’s a lot of focus on the victim of the rape and not necessarily on the person who is the rapist, and maybe the rapist has mental problems as well” (25-year-old female nurse student in interview).

Stakeholders in PH commented on these values, stating “Haitian culture is very hard on the girls growing up here”. Among the grown up women, it was stated that: “The men beat the women every day”. The comment was directly followed by a joke: “then they get together and make a baby” – understating the severity of the issue. The SGBV seen in Haitian culture leave both traumas and fear among the vulnerable. The fact that there is a notion of accept, both among men and women, for domestic violence implies how long the road is towards equity between sexes in Haiti. Hand in hand with acceptance of the fact that it happens – ‘It’s just the way it is’ – comes the taboo and shame of talking about the fact that it happens.

Such taboos will keep the women from seeking help, and if they do seek help, it will keep them from telling the truth – and thereby keep health care interventions from targeting the true issue. Both living under the fear and, for those who have encountered it, the traumas from SGBV, can lead to a big variety of symptoms and suffering – often psychological or psycho-somatic. In
Haiti, where accept for psychological suffers are low, there is seen a tendency towards
(ufullstendig setning)

**Traditional health care and cultural context**

“I used to have a sister who helped me with my kids – gave me a little money when I needed. But someone sent voodoo on her and because of that she’s very sick and can’t do anything anymore” (40-year-old woman in focus group).

The belief that diseases are caused by voodoo spells and spirits, is far from uncommon within the Haitian cultural contexts. Haiti’s religious belief is a syncretism between Catholicism and a Voodoo religion with its roots in East Africa. Most people believe in the Christian God, and a syncretism of Christian saints and the spirits of the voodoo religion, called ‘lwa’. In most neighborhoods or villages, you will find a voodoo priest or herbal healer, who serves the traditional ‘health care system’ (34). Although, from my experiences at the site, the health care available to the local population was dethatched from these deep, cultural beliefs.

Through my visits to Haiti, I have learnt that both voodoo priests or herbal healers and church priests or pastors are commonly used as first advisor on healing for both physical and mental illnesses (35). The strong belief in traditional medicine seems to interfere with the contemporary knowledge provided by health workers and to challenge the impact of modern medicine. However, most Haitians I have met see the traditional medicine as a strength, keeping them in line with their *lwas* and connected to own traditions and roots. The religious roots, are leading back to eastern Africa, to France and Spain and to the traditions of the aboriginal population of the Haitian island, the Taïnos (36). These wide spread roots might give people a feeling of belonging to many different parts of the world, and a feeling of pride (37).

The Haitian pride is quite famous and found existent among the participators of this study. Their pride stems from the Haitian nation’s origin as the first succeeded slavery revolt, and the first free black nation in the world (38).

**Proposals for solutions**

**As presented by the local population in focus groups**

In general, discussing solutions to their nation and neighborhood’s problems was much harder facilitated than talking about the actual problems. It seemed as the task of searching both explanations for, and ways out of despair, were tasks unfamiliar to them. Anyhow, with a little encouragement, they soon saw possibilities at many levels of society.

**Government**

Haitians are often quick to blame the government for their misery. When discussing solutions to their health problems, they often get frustrated; knowing their right to a better health care gets too little attention by the government. Focus group participants were clear on holding the government responsible for much of the problems causing misery. At the same time there was no recognition of the government actually presenting a solution – at least not in near future. “The government can solve the problem, but it’s not able to” (32-year-old woman in focus group).
One comment suggested a way of responding to the lack of movement within the government: “The government doesn’t take its responsibilities because we don’t have an organization who put the people of the neighborhood together to demand from the government. For example, we have the river, and when it’s flooded it kills people. We should ask what they could do for us. If this area had an organization that could sit down with the government, this could work” (38-year-old woman in focus group). Furthermore, there seemed to be a distinction between organizing of local forces in councils or community meetings, and political demonstrations. To the people I lived among in Delmas, it seems as if demonstrations are prone to violence and not a constructive way of demanding action from the government.

Among themes concluded less likely to get an improvement through the government, there was though, one issue, agreed to be adherent to governmental organization: justice. Both the types served by the legal system and the police forces. Only with a functioning system for catching and prosecuting crimes, will there be a possibility for justice. “There has to be justice. It has to establish law, to make sure that no bad things happen. And they have to come with sanctions for the person that is offensive” (36-year-old man in focus group).

‘Tet Ansanm’

A phrase often used to term grassroots movements or local neighborhood governing is ‘Tet ansanm’ (Heads together), used as ‘putting our heads together”. Haiti has a strong tradition for ‘tet ansanm’ and the afore mentioned ‘konbits’. During discussions on the theme, the participants give examples of neighborhoods they know building their highly required road, and making systems for removing the neighborhood’s garbage dumps by putting together – instead of waiting for the government to do it. However, as outlined in previous sections, the unsafe, urban lifestyle has shattered these traditions through means of distrust.

“If we put our heads together we would do two stuff: try to get security and try to get a job.” (36-year-old man in focus group). Another man disagreed on their ability to create security, stating: “You do have time, but you will not be able to take [insecurity] away. It will not be resolved. “If we were to put our heads together it has to be something that can create jobs.” (35-year-old man in focus group). The other men nodded agreeable, and a third man explained: “For example; if there’s jobs, one would not have the time to go stealing so much, or kill someone. If there was security, I could do whatever I want to” (28-year-old man in focus group). The male focus group, also called for stronger involvement of people with money and power in the private sector to work ‘tet ansanm’ with people like themselves, to create jobs. “For example wheel barrow jobs. We see it as violence if they don’t do this effort to create jobs in their society” (35-year-old man in focus group).

The female focus groups also agreed that ‘tet ansanm’ was important for their well-being. “As long as we don’t put our heads together, there will always be someone in misery” (32-year-old woman in focus group). The women’s discussion on possible interactions when joining local forces was broader, evolving around both ways of creating jobs, but also around ways of creating care: “Young men and young woman treat old people badly. They should put their heads together to take better care of the old people. (48-year-old woman in focus group)”. The men again,
leaving their discussion around creating business and jobs in their neighborhood, brought up one of PH’s microbusiness projects to illustrate how the neighborhood should put together to sustainable businesses for themselves: “A clear example: The Manman Troll bakery. We should all by our bread from the bakery. If we don’t, there won’t be any profit from it” (35-year-old man in focus group).

In the further, following up by asking why ‘tet ansanm’ does not happen more often, they would go back to the distrust aspect presented before. “If you want to do something good you need to have someone you can trust by your side” (29-year-old woman in focus group). Normally proposals for social change goes through a ‘Chéf Katye’ (leader of the neighborhood). Many ‘chef katyes’ are dysfunctional by means of distrust or corruption. “If the person that is like the leader in the neighbourhood is honest, then he should be able to know everyone else is honest” (26-year-old woman in focus group).

Education

“It has to do with knowledge, knowledge sharing and teaching the parents. How parents should take the responsibility. What we woman are getting here in Manman Troll [PH’s Women’s network] is for example learning how to be better parents. Not only by learning how to read and write, but by learning how to be better parents. That’s part of what we are doing here in Manman Troll is that mothers and fathers can come and get some kind of an education on these issues. That could potentially help avoid all the cases of rape for example.” (34-year-old woman in focus group).

There was high consensus among all groups that health workers were important action takers on the issues related to increasing their knowledge on health:

“They can help by teaching, giving information. They can teach how to avoid things – for example cholera, malaria. Teaching how to prevent things, for example malaria, (...) how to keep their houses clean, have their garbage apart from where they are living. All these things are important to prevent these problems. More sensitizing, more training, more information, campaigns with information” (28-year-old woman in focus group).

“The health worker, along the things that they already do, like giving aid to people, they can pass a message, which could help all the population. They could help the people by giving them advice” (36-year-old man in focus group).

Most of the focus group participants replied that they had met community health workers in their neighborhood, but rarely more than once. As one of the men stated: “It’s not that much, so it’s not enough” (36-year-old man in focus group). The focus group participants also had many suggestions to where the health workers would get access to the poor populations of their neighborhood, shortly summarized by a 28-year-old man: “It could be in the hospital. It could be in organizations, churches, in the school, work, even on the streets you have people”. The male group, discussing the theme of knowledge from health workers to the furthest, even suggested they could help out themselves:
“We are a few people here that would like to help them out. We would like to also give advice to people on other important issues, so if we can work together, we will be able to give our messages to everywhere” (35-year-old man in focus group).

Happiness

During one part of the focus groups, we discussed what brings the participants happiness. The discussion evolved around whether you could live a life on the bottom of the social ladder, poor and vulnerable, and still be happy, and became quite excessive. I will therefore let the quotes given speak for themselves:

“We can have problems, but we can still be happy” (31-year-old woman in focus group)

“Like me” I don’t have house [because the Hurricane Sandy took it], I don’t have food – but I do have God, so I am happy (29-year-old woman in focus group)

“I am happy because I have God in my life. If you don’t have God in your life, you can have a lot of money, but you will still not be happy, because you will have another type of problem” (34-year-old woman)

“I don’t have much money and there are a lot of things that makes me happy. For example: I have 6 kids. They’re all in school. They have their uniform, their shoes, their backpacks. I got it all ready for first week of school! I feel very happy about that!” (38-year-old man in focus group)

All of the focus groups still distanced themselves from the very bottom of the social ladder, stating there were people living in deeper misery than themselves: “But there are people that don’t have anything. The way that I can smile – they don’t have it” (28-year-old man in focus group).

Proposals for solutions, as presented by health workers in Delmas

The community nurses interviewed in this research, both agreed that the best way they as health workers could contribute to reducing the thrives of the local population and strengthening their health and well-being was through education. They saw spreading their knowledge through seminars and home visits as their biggest opportunity to help. They wanted to get chances to perform their tutorials on tuberculosis, AIDS, child vaccination, family planning, and general physical violence to a further extent. They also wanted to expand their work of visiting people in their homes. Through their work they see it as a difficulty for mothers to feed their children the right way, if they don’t have the money. They therefore suggested more education to women, to ensure them a more stable jobs and income.

Dr Woolley, as a spokesperson for Sante pour Tous, argued: “All Haitians are anyway in need of attention to health issues”. Both economically strong and the poor strata of the population. As the public health care is too chaotic and thought of to belong to the lower social classes, people with money will seek the private clinics, which raise the prices high and leaves even the middle and upper class’ access to health care limited. Providing a cheaper health care system has thereby
become Dr Woolley’s mission. He agrees with the nurses in that spreading knowledge on health issues throughout the Haitian population is of great importance. He also seeks to standardise the entrance to health care - exemplified by his programme of enrolling families and schools to his pre-paid health care system. Through the schools, he has a route of communication and follow-up of his young patients. Through parent meetings, he also gets the chance to ensure knowledge builds up within the whole family.

Dr Woolley’s other grand argument is the importance of building up a health care intervention over time. Not jumping in – promising more than you can. “We have to build the programme. Every year we are adding something, adding a speciality. So until we are getting completed – at that point we can make a move towards a bigger part of the community”. Even though he knows the immense need for health care access during the night, he needs to be honest on the challenges needed to overcome:

“When we grow larger and get the facilities of a hospital, we will start being open 24 hours. Because, you must consider the economic aspect of that problem, because as soon as you have an hospital, you have three shift of people working. Paying the first shift, the second shift and the night - you have to be strong enough economically to respond to that. So, we are not at that point yet”.

DISCUSSION

Summary of results

In a short summary of the results of the present study, the following findings are central: First, the participants, comprising local people, the nurses of PH and Dr. Wolley, the physician from SpT, identified poverty and lack of knowledge of health issues as the main cause of bad health in the area. In focus group discussions, the participants pointed to discriminating infrastructures, both within and between health care institutions, and even inherent in the local transport system. They also addressed their feeling of being humiliated when at the hospital. The nurses, on the other hand, had observed a lack of will among people living in poverty to seek help from the official health system. Dr. Woolley agreed to the problems within the current official health care system, leaving the most vulnerable strata of the local population with little access to care.

Next, several phenomena representing structural violence could be identified at the core of a broad specter of the area’s unhealthy conditions. These could be differentiated as follows: an inadequate law system engendering insecurity; widespread corruption on all levels of society; distrust towards social institutions and authorities as consequence of the former; social inequality linked to race, class and gender; and sexual and gender based violence. In addition, traditional ways of health care and cultural beliefs were potential barriers to more appropriate help.

The participants expressed their distrust with regard to governmentally induced changes in the near future. They sooner expected health workers in local, national and international NGOs to provide appropriate education and information regarding health for the population. The local participants also wished for more general schooling and improved cooperation in creating jobs,
either through engagement of private investors or NGOs. In addition, they claimed that measures engendering happiness might improve their health and wellbeing independently from money. The nurses of PH had no immediate proposals as to how to improve their current work to a further extent. And the physician focused mainly on disease prevention and treatment.

**Delivery and access**

Relating these findings to an evaluation of the health care services provided to the population in this study calls upon the notions access and delivery. Access to health care depends on many conditions. These are, on the one hand, typically described as ‘patient-level variables’, such as use of health care in general and attendance to traditional healers in particular, educational level, environmental and social conditions and their predisposing characteristics. On the other hand are so-called ‘healthcare systems-level factors’, denoting the prevailing structures for both access to and delivery of health care services, such as national laws, programs and distributions, private sector involvement, and health economy. Both provision and delivery of available and achievable services are preconditions for reasonable rates of utilization. They depend on a broad specter of factors, which all need to be taken into account (1, 17, 39, 40).

One of WHO’s standardized measures for access to health care in a country is depicted in a graphic on utilization of health care services on Haiti. Apart from tuberculosis treatment, Haiti scores very low on four defined parameters when compared to its WHO region, the Americas. Especially for three of these ‘contraceptive prevalence’, ‘antenatal care’, and ‘births attended by skilled health personnel’, Haitians seem to be reluctant to seek professional assistance, even though first line public health care is free or cheap enough for most people. These figures, however, do not solely show that Haitians hesitate to seek help from the health care sector. More probably, they reflect low accessibility for greater parts of the Haitian population – an interpretation also provided by Pan-American Health Organization (PAHO) in their more comprehensive country profile (41).

![Figure 3](Image)

*Utilisation of health services*

- Data refer to the latest year available from 2007.

<table>
<thead>
<tr>
<th>Service</th>
<th>Country</th>
<th>WHO region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptive prevalence</td>
<td>35</td>
<td>74</td>
</tr>
<tr>
<td>Antenatal care (4+ visits)</td>
<td>67</td>
<td>86</td>
</tr>
<tr>
<td>Births attended by skilled health personnel</td>
<td>37</td>
<td>94</td>
</tr>
<tr>
<td>Measles Immunization (1-yr-olds)</td>
<td>65</td>
<td>82</td>
</tr>
<tr>
<td>Smear-positive TB treatment-succes</td>
<td>81</td>
<td>75</td>
</tr>
</tbody>
</table>

*Utilization of health services in Haiti, shown by standard measurement in WHO country statistics (2).*
The findings from this study support the observation of a discrepancy between the need and utilization of current public health care services. The local participants delineate profound reasons for their abandoning of health care services, if not in emergency. Firstly, the officially free or cheap public health care is utopic for the poor strata of the population since the real price follows from a different calculation: bribes for bypassing the queue, loss of income due to absence from work, costs of transportation and eventual further admissions, and the price for tests and medicines.

Secondly, all informants agreed that they were in need of more knowledge about health and disease issues, preventive measures, when and where to seek help for what, in order to improve both their health and wellbeing and their access to health care. At the time being, most people go to the general, public hospital for all health issues, sometimes waiting a whole day before seeing a physician briefly who concludes that no medical treatment is needed. The community nurses – deemed insufficiently visible in the community by the participants – voiced their intention to make more home visits as their contribution to improved accessibility.

Contradicting the voices of the participants, the nurses talked about that local people lacked the will to seek health care services. They argued that, having themselves offered classes on perinatal care, family planning, prevention of and testing for sexually transmitted diseases (STDs), and the availability of free services, had not resulted in increased utilization. Thus, they interpreted their observations as indicating lack of will on the side of the local people.

Linked to the previously described context of this study, persons like Mirlande and her neighbors, experiencing poverty, distrust in health personnel, daily grave distress, and inappropriate knowledge, are disadvantaged with regard to both aspects of delivery and access. For them good health care is neither available nor achievable. This represents, in its own right, a structural violation, which is further aggravated by the violating structures of corruption and social inequalities.

**Pedagogy of the oppressed**

The Brazilian educator Paulo Freire – and his followers – has delineated and emphasized the implicit ethical challenges grounded in asymmetries of power when teaching vulnerable, destitute and oppressed populations. But not only ethical issues are at stake, The most fundamental of principles in pedagogy, aiming at facilitating the students’ ability to learn, can be endangered if not basic precautions are safeguarded. Especially among people with high rates of illiteracy and little or no education, these problems occur (42, 43). As Freire puts it: “*Any situation which ‘A’ objectively exploits ‘B’ or hinders his and her pursuit of self-affirmation as a responsible person, is one of oppression*” (42, p55).

When applied to one of the aspects of this study, the power imbalance between the local people and a nurse, whose professional training and salary places her in this society’s middle class, is obvious and needs attention when planning and conducting tutorial interventions among the local, poor population. If these aspects are neglected, the energy spent on gathering local people for necessary information on health issues might be in vain (44). Facilitative concepts, on the other hand, are community based participatory models for planning and intervening (33, 45), and training of trainers, where health personnel train lay people to give the necessary tutorials.
themselves (13, 46). Both approaches transgress power inequalities by enabling “equals” to teach whereby empowering the local community and engendering hope to overcome the prevailing societal or political oppression (43, 47).

In the Haitian society both unfair treatment and oppression of the poor and most vulnerable parts of the population are facts. Freire states that “[w]ith the establishment of a relationship of oppression, violence has already begun” (42, p55), whereby identifying violence as grounded in societal structures. Oppression, one type of structural violence, is “hidden” for the oppressed themselves by means of traditions or other kinds of legitimation because, in Freire’s terms, “their perception of themselves as oppressed is impaired by their submersion in the reality of oppression” (42, p45). Freire’s reflections are mirrored in the present study linked to the phrase “that's just the way it is”, which was often used as a conclusion by the local participants. Consequently, types or kinds of structural violence and its consequences, such as, for example, restricted health care access, need to be elaborated.

*Health in the midst of Structural Violence*

Structural violations afflicted upon the lowest class, the poorest and most vulnerable in the Haitian society, prevail in many areas and on several levels, some of these presented in this report. Structures, which violate people’s health, causing deaths by the hundredth of thousands, are numerous in the history of Haiti. They informed the building of the nation on the background of a brutal enslavement of Africans and are implicit in the free trade deal imposed on the country by the Clinton US-government in 1993 – which since then has ousted the country’s own farming production. Violence is implicit in the national police force of today, since most of its leaders also were in leading positions in the brutal militia of dictator Duvalier Tonton Macoutes, which killed hundreds of thousand civilians. Another example is fragile buildings, which, during the 2010 earthquake, killed hundreds of thousands. Yet another is the contamination of Haiti’s people by Cholera, imported by one of the most controversial of the world’s UN Peacekeeping troops. To these examples of structures, well-known to all Haitians, adds that health care services are both insufficient and unequally distributed, which reflects in the health statistics shown in the Background.

As outlined in the Results, the term “structural violence” was not identified and discussed directly in focus group discussions due to its hidden, structural character. However, the analysis of the data in this study confirmed that structural premises for Delmas’ poorest population cause both suffering and premature death. The study has also shown institutional infrastructures to be among the main barriers for local people’s access to health care, among these: lack of money to pay for the costs of medicine, bribes, tests and transportation between health care institutions – all of which identified by the local participants themselves.

All informants in this study addressed the profound poverty piercing the majority of the area’s people, leaving them with little chances for a healthy life. Still, when it comes to the impact of poverty, it might be fruitful to look to Haiti’s neighboring country: Cuba’s health indices equal those of developed countries, even though the nation’s per capita income equals that of developing countries (48). In other words, poverty as such is not necessarily “identic” with bad health or lack of access to health care. Along with poverty, the study participants identified the
lack of jobs and security as central sources to bad health. Furthermore, they deemed the
government incapable of changing policies and economy due to corruption and nepotism in the
ruling class.

**Corruption kills**
Among the most obvious violent structures stands perceived corruption. The higher the rates of
perceived national corruption, the sicker the people; and the lower a person’s social rank, the
clearer is this person’s perceived corruption – impacting health adversely (49). In a study on the
impact of perceived corruption on health matters, Matthieu Hanf and his colleagues conclude that
“annually at least 140 000 children deaths could be related to corruption” worldwide (50, p5).
Health care systems are shown to be particularly prone to corruption due to large numbers of
actors who share and crystalize information and responsibility, “in ways that make the system
vulnerable to corruption and that hinder transparency and accountability” (51, p13). Corruption
on both national and industrial levels is highly correlated to deaths and injuries from poorly
constructed buildings collapsing during earthquakes (52). As corruption and health interrelates at
such a variety of levels, anti-corruption mechanisms need to be integrated in all initiatives related
to health care (50, 51). In the case of Haiti, one of the world’s most corrupted nations, one is
faced with a particular complex of challenges: located between tectonic plates and, as such, prone
to be shaken by earthquakes, all local health initiatives are particularly responsible for targeting
corruption.

Solutions presented internationally on how to fight corruption in health care cluster around
continuous education as to the ethical standards for health care workers at university and all other
levels; peer pressure from colleagues; strict governmental regulations; limited industrial
involvement; and lawful punishments in terms of fees or imprisonment or disciplinary action
(53). Familiar with the potentially fatal impact of corruption, and witnessing the exclusion of the
poorest, PH and SpT are in position to promote accountability and transparency in the combat
against corruption.

**Overcoming social inequities**

International epidemiologic evidence documents that the distribution of sickness in most societies
follows social determinants such as race and class, mirroring substantial health inequities. This
has engendered theories about social gradients in health, linking social class, level of education,
etnicity, gender, and race not only to graded risk of sickness but also to limited access to health
care (17, 39, 54). At present, social inequities increase, both across and within nations, which,
notably, may destabilize nations and increase the global burden of diseases (55). A well-
developed primary health care system has been identified as the best measure to counteract a
further widening of this gap of social inequity, as “The poor are the natural constituents of public
health, and physicians are the natural attorneys of the poor” (17, p1690).

The informants have underlined that women are especially at risk for poor health. An interesting
discrepancy in my results concerns the nurses’ weighting of their tutorials on family planning and
contraceptives to promote health in the communities, while the focus group participants did not
even mention it. The physician also gave family planning and contraceptives priority. The female
focus group participants could describe, in great detail, the difficulties of raising many children,
often singlehandedly. This might indicate a tabooed topic: family planning and contraception. Due to the limited resources among Haitian women, this leads to a “reproduction of inequities”, where the amount of siblings determines the opportunities for a Haitian child (56).

Applied to the present study, fighting for social equity will, consequently, be a crucial challenge in the future collaboration between, PH and SpT, the primary care-oriented NGOs presented here (24). The study’s material also demonstrates the significance of social capital in Haitian society, a theoretical framework developed by Bourdieu, denoting how a person’s social standing and network enhances health and wellbeing (57-59). Strengthening different aspects of what constitutes social capital, work in civil organizations, churches or communities could stabilize relations and networks whereby reducing stressors and enhancing resources in poor neighborhoods (59).

Equal access to education is identified as a key to reducing social and health inequities, which also was addressed by the participants in the present study. They asked for better education in general, and not only related to health, valuing the power of knowledge in their fight for closing the gap of both social and health disparities (1). They identified appropriate sites for lecturing (especially on health): the street where most of them work; at other work places; in schools; in churches; through the many civil organizations in their neighborhood; and at the local hospital. The community nurses added people’s homes to their list, acknowledging the necessity to address different health issues in a wider audience. However, they were not critical to their own pedagogical measures, which might call for an evaluation.

The participants also proposed the possibility of creating jobs in cooperation with private investors among the richer people in their neighborhoods. Such cooperation, when performed properly, might counteract the social gap. They spoke with pride of the successful bakery of PH, providing jobs for its bakers and administrators, and for approximately 60 women selling the breads on the streets. Although doubtful whether similar projects might be established, they nevertheless embraced such initiatives with hope, belief and trust, reflecting the empowerment inherent in the example – showing that the impossible is possible. The power of hope among vulnerable people is well documented in Paulo Freire’s work Pedagogy of Hope (47).

‘That’s just the way it is’
The term “structural violence” was, as outlined under the result section of this report, coined by Norwegian peace-researcher Johan Galtung (26) who also delineated its consequence as follows:

“The underlying assumption is simple: ‘violence breeds violence’. Violence is needs deprivation; needs deprivation is serious; one reaction to needs deprivation is direct violence. But that is not the only reaction. There could also be a feeling of hopelessness, a deprivation/frustration syndrome showing up on the inside as self-directed aggression and on the outside as apathy and withdrawal” (60, p295)

The present study supports Galtung’s reflection. It shows that growing up in an arena of violating structures leads to blaming the government and concluding with “that’s just the way it is”. This applies especially for phenomena like corruption, but also for phenomena such as the Haitian “tét ansanm”, meaning “putting heads together” in order to engender changes. In the sense of
Galtung, the participants show “self-directed aggression”, blaming themselves as too selfish or too lazy to practice “tét ansanm”, whereby prone to respond with apathy while blaming both the corrupted government and themselves for their position at the bottom of Haitian society. Still, the study also shows how this view changes in the face of proof that social action implies progress in living conditions. Involving community participants in the development work, empowering them to take action for change, has shown to enhance health outcomes – locally and globally (33, 45).

In other words, the violent structures surrounding the lives of my participants, has negative consequences, leaving Haiti at the bottom of health statistics both in its region and in the world. Fighting these structures feels like a hopeless enterprise for many, but changing the nearest surroundings and reducing violent structures in their own neighborhood is exactly what my nearest collaborators aim to do. In the material of this study, the local informants have made suggestions about how the two organizations can strengthen their work in the primary health care sector. Grounded in the frames of the two study collaborators, I will search to support and extend the participant’s suggestion through knowledge found in literature on how primary health care is provided at similar venues in the world.

**Searching proposals for primary health care interventions**

Despite violent structures and subsequent apathy, this study has also found resilience to hardship among the participants. The study has found happiness as a source to battle distress in everyday life, and therfor add to wellbeing and health. The focus group participants named happiness to be independent from social rank and rather depend on pride of how well they manage, and the progress they actually make, with the little they have. From daily discourse, this courage seems to be a cultural thing, stemming from their proud beginning years of freeing themselves from slavery. Their wide spread roots, visible in their religious diversity, evokes a feeling of belonging to many different parts of the world, and adds on to their pride and feeling of social security (36-38). Religious and traditional beliefs also informs their traditional health care system of Vodou priests and herbal healers (34). Consequently, a successful intervention on health in Haiti must take both sides of the backdrop into account; the paramount presence of structural violence, but also the pride, courage and happiness springing from strong affiliation to traditions and self-sufficiency. Ownership to the project among the targeted population is therefore important (61).

There is already strong local ownership among both collaborating NGOs to this project. They are run and owned by Haitians, although lack of education makes it difficult for members from the lower classes to take on leading position – especially in SpT, where a certain level of health education is a prerequisite for most positions. To enable responding to my research question, and provide proposals to my two collaborators on how their collaboration can improve the primary health care in Delmas, I need to lay the frames of my local collaborators as the foundation (these are found on page 9 in the background). Through the means of these frames, and the local voices and contexts presented above, how may literature guide my final proposals for further action?

**The Community Health Worker**

Great inspiration for providers of health care is to be found in one of Haiti’s prides: Zanmi Lasante (Friends of Health), the mother project of a world leading global health care organization
called Partners in Health, founded in Haiti’s rural Central Plateau in 1987, and now running broad health care interventions in 12 different countries (62). At the time being, *Partners in Health* is collaborating closely with the Haitian Ministry of Health on developing the national health care system. Thus, primary health care in Haiti may take onboard one of the core ideas from *Zanmi Lasante*. The main message from *Zanmi Lasante* and *Partners in Health* are so-called *Accompagnateurs*, or community health workers.

These are recruited from the local community and employed to give home based care and be a “vital link between village and clinic” (46, p152), providing profound insight into the conditions of their community’s inhabitants, even the most vulnerable among these, e.g. sick, disabled, orphans and mentally ill. Aiming at improving the health and wellbeing in their local community, they offer health education and prevention of specific diseases, seek out those in need of testing or treatment quite actively, refer patients to other levels of the health system, and perform basic treatment and management of diseases, both physical and psychological (46, 63). *Accompagnateurs* have played an important role in drastically reducing rates of both HIV and tuberculosis on the Haitian Central Plateau. Similar interventions on HIV and tuberculosis have been successfully implemented in different and deprived settings, both rural and urban, in a strictly cultural-sensitive manner (46).

*Partners in Health* has assisted the Rwandan Ministry of Health in similar ways as they now are invited to by Haitian authorities: strengthening a multileveled health system; building or restoring hospitals and health care centers; recruiting and training health professionals; and introducing community based HIV care together with basic primary health care interventions (64). The enhancements of the Rwandan health care system has been impressively successful, providing “some of the steepest decline in mortality ever documented, anywhere and at any time” (64, p166), leaving Rwanda the only country on Sub-Saharan Africa that is on track to meet the health related Millennium Development Goals by 2015 (64).

Providing health care by reaching to private homes is a common practice in most traditional health care systems (65), and is also applied in contemporary primary health care, as, for example, in Cuba. Cuban health authorities have regarded good primary health care the most important means to improve health indices since the 1960s – long before the Western countries met to form the Alma Ata Declaration in 1978. Cuban health care is based on rural out-clinics that are staffed with specialist physicians in almost all clinical specialties who prevent large numbers of patient admissions to hospitals. Primary health care services, distally organized with consultarios -- small first line clinics integrated into neighborhoods lead by family physician paired with nurses to serve some 150 families each, dividing the office hours equally between seeing patients at the clinic and at home, the latter mainly for the purpose of prevention and care for chronically diseased people (66, 67). Haitians identify with Cubans, both historically and culturally, and the Cuban solidarity brigade of doctors has worked in Haiti for many decades, preventing and treating diseases, while also training and educating Haitian health workers. After the earthquake, Cuba responded immediately by sending emergency teams which worked efficiently, a fact that, however, has not been reflected in a fair manner in the media (68). Although a great inspiration to Haitians, one must keep in mind that the Cuban model is grounded in a political ideology quite different from the prevailing Haitian.
Applied to the present study, the participants’ of which claimed better access to health care services and improved economy and infrastructure, introducing systems like *Accompagnateurs* or *Consultarios* into Haitian health care might be a change to the better. This even reflects the male focus group, stating that they would like to help the health care workers out. Still, even more radical or comprehensive models may be necessary. This may resonate with the voices of two community nurses connected to PH, advocating extended possibilities for home visits (done through their engagement with another local health care organization), as a valuable contribution to preventive work on community level. They reported never to have met other community nurses in their neighborhood, and hardly ever in other places than organized by churches or affiliated NGOs. Yet given the proportion of slum dwellers among the inhabitants of Delmas, the paramount lack of health workers in the country, and the quite limited health budget, training lay people as community health workers in cooperation with professionals seems to fit the area of Delmas.

*Creating innovations sensitive to local contexts*

Positive changes in primary health care delivery and access in many developing countries have occurred based on suggestions from community health workers (69), often providing an appropriate starting point for quite specific local improvements combined with easy access to evaluate interventions with regard to their sensitivity to cultural contexts (15). In Kenya, community health workers improve infrastructures by visiting remote patients either by four-wheel drive vehicles, camels or by feet. All over the world mobile health -- termed mHealth -- is spreading to resource poor settings (70). Increasing evidence lends credibility to mHealth and community health workers (70, 71). In addition, *Partners in Health*, while working consistently by means of community participation, has developed a *Program Management Guide*, an introduction into how to build a sustainable, comprehensive and locally sensitive health care organization in rural areas of the developing world (63).

Cheaper and more effective inventions have also come from being forced to work with limited resources – as physicians and health workers in developing countries often do. A great example of this is the Kangaroo Mother Care (KMC). KMC is an alternative to conventional neonatal care of low birth infants, well suited for resource poor settings (72). KMC was developed in Colombia in the 1970, and the method is now further tested as a national research program in South Africa, showing tremendously positive results on deaths among preterm and low-birth-weight babies (69). Low birth weight and preterm births are highly associated to infant deaths. Instead of depending on expensive specialized equipment, the KMC bases their infant care on skin-to-skin contact and exclusive and frequent breast feeding (69, 72). Another great source for health care innovations, is the online database of Centre for Health Market Innovations, and their “Innovator’s Handbook” on primary care, promoting accessible and affordable health care for the world’s poor, delivered by the private sector (73).

Such innovations inspire and add to a necessary knowledge base of alternative ways of providing primary health care in resource poor settings. Both perspectives are important in the collaboration between PH and SpT and their wish to intervene in the primary health care sector. Sometimes, there might even not be a need to “reinvent the wheel”; for example, even though Zanmi Lasante, works in rural parts of the country, some of this material is relevant for urban slum residents, not
because they live remote and out of reach, but because they are restricted by social and economic barriers (63). Although, the need to take precautions for innovations to make interventions locally sensitive, must always be nurtured.

**Learning from others’ mistakes**

With regard to corruption and social inequalities in Haiti, experiences from developing countries criticized exactly for decentralised primary health care models might be useful to consider. Brazil’s *Programa Saúde da Família*, or *Family Health Program*, has met a competitor in private care distributors. Although financed as a mandatory national health insurance, people who can afford private care are allowed to quit the public care program. Given the economic growth the country has seen lately, more and more people leave poverty and opt for private care. This tendency has jeopardized the aim of universalism for the Family Health Program (74, 75).

South Africa, with racism still lingering since its brutal Apartheid period, sees increasing class segregation among the black population, endangering the maintenance of a health care system based on equality. Suggested priorities for the future include improved macroeconomic policies targeting poverty, unemployment and inequities (76), and – with regard to corruption – improved leadership, management and systematic surveillance of the system by means of participatory models including lay persons (77, 78).

Could PH and SpT’s work in Delmas learn from these mistakes? Both are private organisations, thereby not fitting in an eventual governmental move towards universalism. Still, both offer an appropriate compensation for the lacking access to health care in the current public system. SpT’s philosophy of targeting the poor, but being open to everyone, rich as well as poor, seems to be a model to be in line with international global health advices. Both SpT and PH dispose limited space for their establishments, and in addition PH faces economical limits, and SpT a shortage in number of staff. Future health improvement within the Haitian population seems to require a close collaboration between private corporations and the government or a purposeful investment and engagement by the Haitian government itself.

**Following international guidelines**

WHO, *Partners in Health* and the previously mentioned academic global health care activists Paul Farmer and his colleagues provide guidelines to support organizations when starting primary health care interventions. WHO offers general guidance, similar to checklists, to ensure the comprehensiveness and sustainable, locally sensitive means of an intervention, while *Partners in Health* (by all means, only one example among many relevant NGOs) adapts to the more local level. Both stress the importance of the interventions to be locally responsive, reflecting local voices and advocate for collaborations between health initiatives and other organizations focusing on e.g. education, micro-credit or sustainable livelihoods. They also front collaborations with the local Ministry of Health to secure not to counteract national health care development and to value academic powers of systematic review and evaluate the intervention through means of research (20, 63, 79). While academic global health activists formulate theories about how to avoid unintended negative consequences of actions taken in developing countries in addition to
emphasize the importance of documenting all intervention outcomes, to contribute to the long needed knowledge base on global health care delivery (13, 24, 73).

**Strengths and weaknesses**

A strength of this study is its being grounded in local and other relevant voices. The analysis of this material supports the explicit wish to intervene on PHC in Delmas through the local NGOs PH and SpT. Its weakness is the limited number of health care workers included, resulting in only one voice representing SpT. This voice, however, lends a strength to the material, since the speaking person is the director and co-founder of SpT. On the other hand, this person is, of course, speaking in favor of an organization that represents his own life work. In addition, there are limitations inherent in the imbalance between genders since only 4 out of 22 participants in focus groups were men.

Another limitation is the fact that the research question for the present project was formulated after the material it springs from had been collected. This can have lead the focus group discussions more straightly to the defined topic and less generally explorative. Moreover, the research theme originally chosen, evolved around health and well-being, leaving the emergence of the possibility to seek within the material for proposals to better health care access, as a natural next step.

A further weakness is the cultural and linguistic barrier between myself, the researcher, and the local informants. This necessitated a translator for communication with local people. On the other hand, I had familiarized myself steadily with Haitian conditions during the past 8 years, including a 4 months’ stay. However, being an outsider, yet invited and included in a locally accepted NGO providing me support and legitimacy, may also have contributed to giving me access to types of information otherwise concealed.

Yet another strength of the present report is its focus on proposals designed to fit the two NGOs familiar to the researcher. The report is both expected and necessary for supporting further collaboration between these. Although not having received economic support from the NGOs, both researcher and informants may nevertheless feel obliged to their host respective helper. This may have interfered with their freedom to being critical to these organizations.

**CONCLUSION**

Although strung by apathy, the participants of this study saw “hands on” possibilities to ease their burdens, when encouraged. This study demonstrates that local voices can constructively contribute to the debate on how to improve access to primary health care. Likewise, it shows that community participation is necessary for meaningful innovations in primary health care delivery. This report directs attention to crucial premises for providing comprehensive, sustainable and locally sensible interventions in general.

- Health care delivery in poor areas in developing countries must be **people-based**, serving the people in need of it where they are.
- **Power asymmetries** between the health care system and the target people need to be addressed and balanced, because these are barriers to the envisioned outcomes.
- Involving lay people in **decision-making processes** allows for openness and counteracts distrust and apathy resulting from corruption in the health care system.
- Involvement in transparent and trustful decisions engenders a sense of **ownership that is empowering** the target population to take responsibility for own health and well-being.
- Keeping the **local authorities** informed may prohibit adverse actions to positive changes in the national public health care.

This study demonstrates also that a thorough involvement of the local community identifies actual disparities between envisioned delivery and perceived access. More specific, this study identifies SpT to be the relevant source of health-related knowledge, and PH to be an efficient link to the local population, resulting in the following, particular suggestions:
- Develop **tutorials based on appropriate pedagogy** for PH’s well-established groups of lay people, such as the women’s network and the youth club, to develop tutorials on health issues relevant and designed for the local people.
- Recruit **community health care workers** interested in health care issues among PH’s members as part- or full-time community health workers, starting with volunteering health workers.
- **Document progress and regressions** since program can serve as a pilot for other intervention, thus securing material to build on in the future.
- Plan the **costs of community health workers** with regard to training and salaries in the budget of both PH and SpT with focus on cost-efficiency.
- **Health care centers** should use PH’s facilities for including a school nurse employed by SpT to work with youths and women in particular, planned as a pilot for SpT future work. PH’s local and international network could facilitate further expansion and sustainability.
- Arrange **community meetings** with invited community members and leaders for evaluation and guidance of further work, including mapping of needs and resources (e.g. traditional medicine, local experiences).
- Cooperate with **local government** and present them with the wishes and needs of SpT and PH’s members, thus contributing to positive movements catalyzed by the national public health care sector.

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