

THE EFFECT OF INTERNATIONAL AID AND DEVELOPMENT ON MATERNAL  
HEALTH IN HAITI

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## ABSTRACT

Maternal mortality in an ongoing health crisis in Haiti. Indicators of reproductive health are among the worst in the world with a maternal mortality rate of 350 deaths per every 100,000 live births. The health services within Haiti only reach between 40-60% of the population. There are many factors that affect the dire status of pregnant women in Haiti such as the lack of access to prenatal care, distance to health facilities, and the inability to pay medical fees. Haiti is considered the poorest country in the Western Hemisphere, and the ill conditions of health are directly related to this conundrum. For these reasons, Haiti has been a prime target for international aid. Since the January 12<sup>th</sup>, 2010 earthquake this aid has reached unprecedented levels. Why, then, is the general health of the country still so deplorable?

This study examines the changes needed in development and aid work to more effectively address this maternal health condition and the sustainment of any health projects in Haiti.

Through a literature review, I will study the history of development models and how these different methods have affected the poverty and maternal health of Haiti. I will compare these to alternative development approaches and successful health models in various nations. This literature review will set up a good analysis for my fieldwork in Haiti.

The report of the field study investigates Haitian women's most pressing health needs, barriers to meeting those needs and proposed solutions, and how they think the community and outside organizations should be involved in addressing their needs. It will also address development workers' view on the most effective methods for combatting issues

of maternal health and the extent to which they think community and outside organizations should be involved in addressing these needs.

Conclusions from this study are drawn on what should be addressed differently in the future to more effectively improve maternal health in Haiti.

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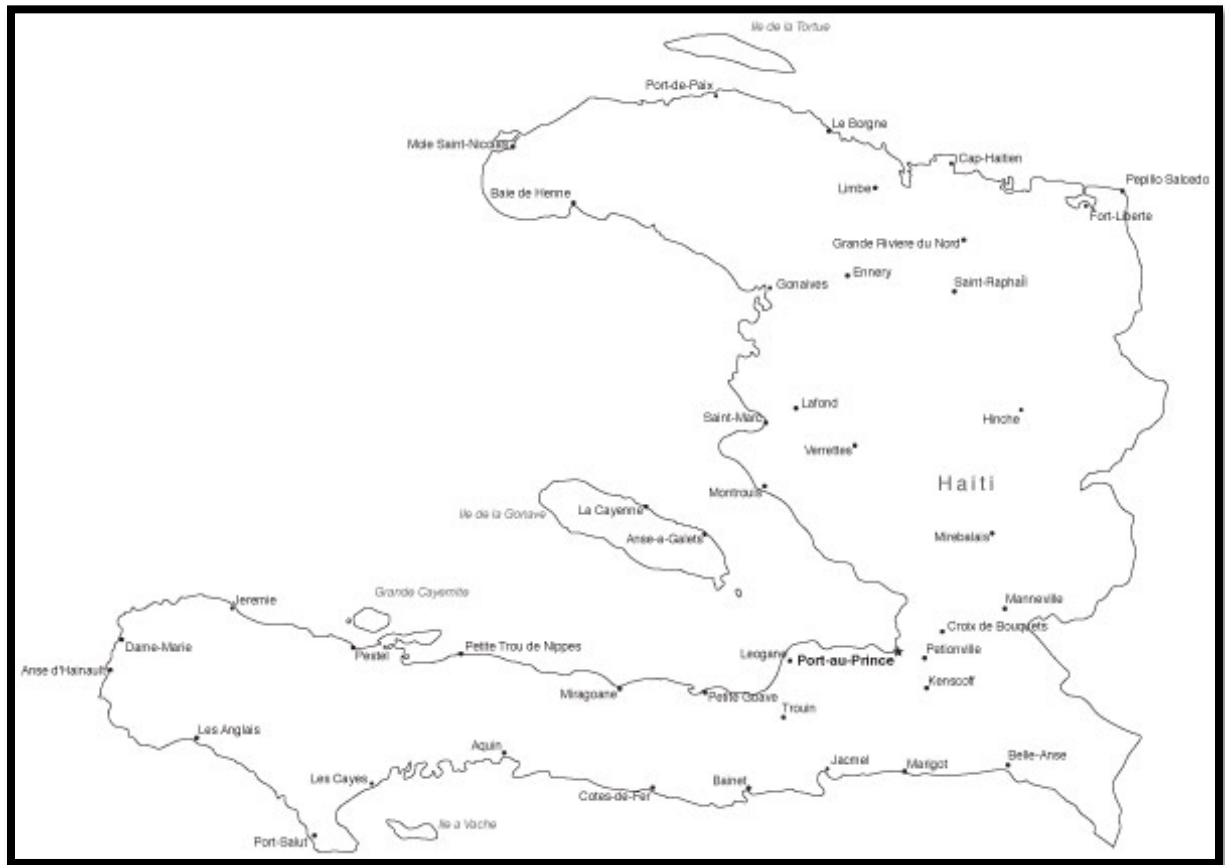
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## HAITI MAP



(Black & White Haiti Map with Capital and Major Cities)

## I. INTRODUCTION

As a result of both its poverty and openness to external interaction, Haiti is a prime target for aid. Since the 1791 slave revolution in Haiti, Haitians have endured continuous western interventions and occupations, internal governmental corruption, and violent episodes. For decades, this Caribbean nation has been subject to international aid through bilateral and multilateral agencies, NGOs, churches, and private donors. After the 2010 earthquake, the aid response from the international community was astounding. The world spent over \$5.2 billion on the emergency relief alone (Katz 2). Private donations reached \$1.4 billion in the US. When it came time to plan for the post-earthquake recovery, the world pledged over \$10 billion with the goal to build a “better, safer, and more prosperous Haiti than before” (Katz 2). Even with all of this aid, Haiti is considered the most impoverished country in the Western Hemisphere and has the highest rates of maternal mortality in the region, with 350 deaths per every 100,000 live births (“Haiti”). Health services within Haiti only reach between 40-60% of the population (Haiti: Health Action in Crisis). Taking into consideration the long history of international aid in Haiti and the current challenges the country is facing, this study examines the changes needed in development and aid work to more effectively address the maternal health condition and the sustainability of development projects in Haiti.

Families constitute a key social unit upon which society is based. If there is any development issue that addresses the most basic of human needs, it is the safety and health of mothers and children during and after pregnancy. For any advancement to be made in creating social progress in the world, mothers and infants need to survive birth. For this reason, I chose the issue of maternal health in Haiti as the perfect lens to discuss the larger



development issues the country is currently facing and the appropriateness of alternative development models in Haiti. The literature on maternal health in Haiti addresses three key aspects of maternal health in Haiti: the access to healthcare, the persistence of poverty, and the lack of continuum of care programs (Beauboef 1). Through looking at these three points and their relevance to maternal health development work in Haiti, many questions will be examined such as: How is the maternal health condition in Haiti being addressed by development workers? Have there been maternal health projects that have been more successful than others? Are there health programming models that could be a better model for improving child and maternal health in Haiti? The structure of aid itself will also be critiqued. Is the traditionally top-down model of international aid with very little community participation an effective model for maternal health development work in Haiti?

Through a literature review, I studied the history of development models and how these different practices have affected the poverty and health of the nation. I compared these to alternative development approaches and mainstream development theory critiques. I also analyzed the different methods that have been used to address maternal health throughout Haiti and their effectiveness.

After conducting this literature review, it was determined that additional research was needed to examine whether or not the current NGOs and other aid organizations in Haiti were attempting to incorporate these development strategies into their work. I also wanted to further assess the community's perception of outsider influence in the development of Haiti. In addition to this, I hoped to evaluate potential alternative development models to improve maternal health. For this reason, I traveled to Haiti to conduct qualitative research with Haitian women and development workers.

I applied the findings identified in the literature review to the Haitian context. This involved exploring questions deemed important by those planning maternal health clinics and development programs focusing on women. I conducted in-depth interviews and focus groups with Haitian women addressing their access to healthcare, their maternal health history, and their suggestions for improvement of the current model. I also conducted in-depth interviews with development and aid workers addressing their projects concerning women's health issues, the most pressing health needs currently, and their opinion on the best way to address these issues.

Through the literature review, on the ground research and observation, and in-depth interviews, I better understand the variety of perspectives regarding maternal health in Haiti. With decades of unsuccessful aid work, there needs to be a development paradigm shift. By understanding the government, nongovernmental, and community perspective on these issues, I address the most promising changes needed in maternal health projects in Haiti to truly create a more equitable, successful Haiti.

## **II. HISTORY OF DEVELOPMENT MODELS**

Although international relations and trade have existed for centuries, through the slave trade, colonialism, and imperialism, only in the past hundred years has international development existed as a separate body of ideas. After the immediate aftermath of the Second World War, this notion came to fruition throughout the many colonies that had gained independence.

The second half of the 20<sup>th</sup> century has been coined the "era of development." A global campaign was then launched for "the improvement and growth of underdeveloped

areas worldwide” (Easterly 24). This movement has taken many forms, including drastic method changes, and the results have been mixed. In order to understand the effect of international aid and development on maternal health in Haiti, it is necessary to put in context the different development models enacted worldwide since this time.

The mainstream economic development approach, which gained immense influence during this era, sees poverty as the main issue in undeveloped countries, and growth of income as the way to increase material well-being (McMichael 48). This well-being is seen in terms of material goods and is measured by the per capita gross national product (GNP). A higher income is achieved by increasing inputs, which therefore increases outputs, or national income. According to this perspective, this is best achieved through a market economy, or capitalism. The purpose of capitalism is to produce the maximum amount of desired output possible, efficiently allocate resources, select technology, and distribute income and wealth (Mankiw 4).

This model follows Keynesian economics, with a focus on state-regulated markets and public spending (McMichael 47). Through this model, the market was liberalized within the constraints of the environment, labor protection, and social welfare (Harvey 11). In other words, capitalism was constrained to ensure entrepreneurship within state parameters (Harvey 11). Richer countries provide aid, loans, and private foreign investment to poorer countries. By doing so, the poorer countries become active participants in the global economy and can use their market power to demand the goods and services the country needs.

This is a universal model, meaning the goals and methods for achieving development are the same for every location. From the mainstream economic point of view, development

is an ongoing process, as technological and economical advancements continue to progress. This development has a strong first-world presence and is led by many international organizations, including the World Trade Organization (WTO), World Bank (WB), International Monetary Fund (IMF), and non-governmental organizations (NGOs).

In Haiti, the mainstream economic approach stressed the importance of increasing income in Haitian society. This economic model followed the mentality that by increasing income, Haitians would have a higher material well-being and could therefore improve their ability to access the goods and services needed. Relating to maternal health in Haiti, it was seen that if income increased, families would be able to afford better healthcare practices. According to mainstream economic theorists, before this model was enacted the Haitians were not able to have a voice in the market to “demand” the health services needed. With this increase in wealth, Haitians would now be able to ask for a higher “supply” of these facilities and the market equilibrium between supply and demand could be reached.

More recently, the focus of mainstream economic development has shifted to a neoliberal approach emphasizing the free market and private control, but the goals of increased GNP through external involvement have remained the same. For example, in the US labor unions were crushed, privatization of all areas of the market was implemented, and telecommunications and finance were deregulated. At the international level, structural adjustment policies were enforced, free trade agreements grew in prevalence, and foreign direct investment was strongly supported. This was done under the ideology that equates development with export led economic growth fueled by foreign borrowing and investment (Mander, Cavanagh 56).

In Haiti, the neoliberal development shift drastically changed the focus of the economy. From 1915-1934, the US occupied Haiti and began the process of incorporating free market practices into the Haitian economy. From the 1970s forward the economy became geared to the private sector. Social services were abolished. Structural adjustment policies were implemented in Haiti. They focused on creating an export-based economy where foreign companies were welcomed. Mainstream economic theory sees this as the most effective way for all economic participants to receive their needs since it prevents the government from interfering with the success of the ‘invisible hand.’

These policies and events have created subservience to foreign capital in Haiti that has exacerbated the poverty and underdevelopment of the island nation (Dubois 6). These challenges, in addition to the lack of recognition provided to the island nation, have made it increasingly difficult for the country to develop a strong civil society, stable political institutions, and a diversified economy (Popkin 7). Maternal health was greatly affected by these policies. With the removal of social services and the focus on external growth, health facilities became privatized, expensive, and no longer the priority of the government.

Throughout the implementation of these mainstream economic policies, Haitians have resisted. In 1986, the Haitians fought a revolution for democracy against the 29-year Duvalier dictatorships that were incredibly brutal. Groups from many different demographics, including women, professionals, laborers, peasants, human rights activists, civic activists, religious groups, and media organizations, came together to prevent another military dictatorship from coming to power (Dubois 3). They fought for a just and inclusive democracy that had to do with social justice, jobs, higher wages, education, healthcare, social services, and land reform (Dubois 3). This revolution not only challenged the dictatorship,

but also the greater global structure in work that was affecting Haiti. This revolution challenged the incredible inequality within Haitian society and the country's subservience to major world powers (the U.S. and France in particular) (Dubois 3). It challenged the very institutions that these powers control, including the World Bank, the International Monetary Fund, and the Inter-American Development Bank, whose neoliberal policies had devastated the Haitian economy and impoverished population (Dubois 3).

In December of 1990, Jean- Bertrand Aristide was elected president by a landslide, promising to carry out the people's cause and fight against capitalism and foreign dominance and interference in the internal affairs of Haiti (Dubois 3). Within nine months the Haitian bourgeoisies forced him out of office and into exile (Dubois 3). In 1994, he was returned to his position as president through the support of U.S. President Bill Clinton and a multinational U.N. military force to complete the rest of his term. He began implementing neoliberal policies, including the privatization of public enterprises, as a condition of his return. In 2000, Aristide was elected for his final term as president, which ended in him being sent to exile for the second time. Since then, René Préval (2004-2011) and Michel Martelly (2011- current day) have been presidents of Haiti. Neither has challenged the neoliberal economic growth policy instituted in Haiti since the 1970s. Haiti continues to be used as a source of cheap and abundant labor for transnational capitalist corporate interests. As a result, national economic models continue to neglect maternal health as a key priority for development in Haiti.

Through all of this, though, the spirit of resistance and search for true democracy has not ceased. The story of the Haitian's ancestors' struggle for freedom is a great symbol of inspiration as this country continues to face seemingly insurmountable challenges.

### III. ALTERNATIVE DEVELOPMENT MODELS

The implementation of mainstream development in Haiti has been wrought with criticism since the beginning. Looking at development projects from 1949 to present, there are many critics in Haiti and worldwide. Two key positions emerge on why these development models continue to fail and can be understood through the lens of maternal health in Haiti.

The first alternative development approach sees past attempts of development as poorly executed and the solution as a change in the process or structure of development. For these thinkers, the current problem stems from the donor-driven agenda in which those high up in development, typically outsiders to the region, make and enforce all development decisions. They create intangible and simplistic goals like “ending poverty by 2050” that in reality are unachievable (Easterly 6). Alternative development thinkers of this mentality believe a change in the methods of development will improve its effectiveness. For them, development should switch to a model that is participatory, transparent, and accountable to the community in which the development is taking place (Easterly 30). The structure of development must also change so that it does not create dependency, fatten bureaucracies, or inhibit the political dynamics of the receiving countries (Black 37). For maternal health in Haiti, this would involve working with Haitian women and healthcare workers to decide how to better improve the health status of the country. The goal to increase material well-being and improve the economic status of the country would still be emphasized in these projects.

The second alternative development approach addressing failed development sees the entire notion of development as a problem and the solution as the abolishment of the

concept. For these thinkers, development, or the constant focus on economic growth, has created a world of binary oppositions. This mentality has separated people into the “haves” and “have-nots” where financial performance is used as a measure of social progress. In other words, development has been framed as success, whereas underdevelopment has become the epitome of failure (Sachs 10). This development discourse prevents creativity and diversity in solving problems because it takes agency out of the system and promotes homogenization and a kind of development monoculture around the world. These alternative development thinkers believe the goals of development and the means to achieve it must be different for each place. They focus on a pluriverse, localization ontology, seeing a world in which many worlds are possible (McMichael 295). For example, these alternative development thinkers would support a paradigm change that looks at nonmarket values, such as human connection and relationships with nature, and more control exerted over development projects by the people themselves. For maternal health in Haiti, this would mean the goals of mainstream development would not be emphasized in maternal healthcare planning. The Haitians would be able to come up with their own priorities related to maternal health and implement them in the way they see as most appropriate.

These two development critiques have interesting and provocative implications for a more positive vision of Haiti’s maternal health future. Alternative development thinkers have varied opinions on what is most appropriate to improve maternal health in Haiti, but most focus on the notion of community-focused development. Key thinkers suggests that the most effective and efficient way to engage in foreign aid and development in Haiti is through “accompanying the intended beneficiaries” in all projects (Schuller xi). This involves development that works “alongside with the communities, walking with them until their



goals become their reality” (Sculler xi). These thinkers believe that change is needed in governmental policy, with a new policy regime that supports community-led development initiated at the grassroots level (Beauboef 34).

After conducting this literature review about the history of development models and alternative development approaches recommended for maternal health projects in Haiti, I felt that more research was needed to examine the gap between development theory and practice. I wanted to see firsthand the reality of aid currently in Haiti and the effectiveness of the current model. For this reason, I traveled to Haiti to conduct qualitative research with Haitian women and development workers. While conducting this research, I assessed whether or not the current NGOs and other aid organizations are attempting to incorporate community-focused development into their maternal health work. I also assessed community perception of outsider influence in the internal affairs of Haiti. In addition to this, I evaluated potential other alternative development models for maternal health in Haiti.

#### **IV. MATERNAL HEALTH IN HAITI**

##### **Maternal Health**

Maternal health is defined by the World Health Organization as “the health of women during pregnancy, childbirth, and the postpartum period” and encompasses the healthcare dimensions of family planning, preconception care, prenatal care, and postnatal care (WHO). Preconception care can include education, screening to reduce risk factors, and health promotion. Prenatal care aims to detect any potential complications with the pregnancy and to prevent it if possible. Postnatal care includes childbirth recovery, newborn care, nutrition, breastfeeding, and family planning.

Maternal mortality, a key issue within the field of maternal health, is defined as “deaths due to complications from pregnancy or childbirth” (UNICEF). Worldwide, the major causes of maternal morbidity and mortality include infection, high blood pressure, hemorrhage, obstructed labor, and unsafe abortion (WHO). The maternal mortality rate in Haiti is 350 deaths per every 100,000 live births, ranking 31<sup>st</sup> worldwide (World Factbook). Haiti has the highest rate of maternal mortality in Latin America and the Caribbean (Beaubeouf 3). Based on the latest figures, only 2.4 physicians, 1 nurse, and 3.1 auxiliaries are present per 10,000 people. The earthquake of 2010 put additional health strains on the population that was already suffering from chronic poverty, vulnerability to disease, environmental disasters, and political insecurity (“Nobody Remembers Us”).

While there are numerous factors that affect the maternal mortality rates in Haiti, I focus on three key contributors: access to healthcare, poverty, and continuum of care. These three factors must be addressed to understand the effectiveness of development projects throughout Haiti. While each factor has unique attributes, they are inextricably intertwined.

### **Access to Healthcare**

Access to healthcare is a key determinant of maternal mortality. Access is central to the performance of health care systems around the world. However, access to health care remains a complex notion as exemplified in the variety of interpretations of the concept across authors (Levesque 1). In Haiti, access to healthcare is contingent upon two factors: distance to facilities and ability to afford care. The main issues relevant to access to healthcare in Haiti can be seen based on the geographical location. Administratively, Haiti is divided into ten departments, or secondary administrative divisions of the country. Other

than the urban area of Port-au-Prince, the capital of Department Ouest where half of the total population lives, Haiti is widely undeveloped with a rural, mountainous terrain (World Factbook). Access to healthcare in urban Haiti is largely based on the ability to afford care. In rural Haiti the additional access component of distance to facilities is incorporated.

Medical services, private and public, are disproportionately located in the metropolitan Port-au-Prince area (Barnes- Josiah 983). The two national referral maternity hospitals in Port-au-Prince account for 60% of all hospital deliveries (Barnes- Josiah 984). While obstetric services are available in urban Haiti, the problem with access to healthcare for urban Haitians is the quality of services and ability to pay. High quality private care is only available to those with ample financial resources (Barnes- Josiah 984). Public facilities, on the other hand, are marked by overworked and underpaid staff and inadequate supplies (Barnes- Josiah 983). While these services are free, the indirect costs associated with meals, drugs, and supplies, can quickly become a burden to the patient's family. Therefore, the majority of families cannot receive the quality care that is needed to ensure a safe delivery.

The largely mountainous, rural areas face additional challenges for receiving adequate and affordable healthcare. While small clinics, dispensaries, and health centers are found in many of the larger villages of Haiti, the rural and semi-rural areas face the most challenges with the availability of health services (Barnes- Josiah 983). Hospitals outside of the city tend to lack key obstetric services, with many small clinics unable to provide delivery capacity or formal maternity wards (Barnes- Josiah 984). The distance to health facilities is also significantly greater in these areas (Gage 1). The time and cost associated with traveling to health facilities reduces the ability for mothers to deliver with trained medical personnel (Gage 1). Frequently, these factors reduce the likelihood of mothers

seeking additional care such as prenatal and postnatal care. The topography and poor road conditions prevent travel to facilities even if the family has the ability to pay. Crucial services are not reached in a timely manner and the status of the baby and mother are affected.

### **Chronic Poverty**

Separate from the ability to pay for health care, poverty directly affects maternal health by worsening the conditions that cause sickness and disease. Haiti remains the poorest country in the Americas and one of the poorest in the world (World Bank). The per capita GDP was \$1,575 U.S. dollars in 2013. Haiti ranks 161 out of 186 countries in the Human Development Index. The overall poverty headcount is 58.5 percent, with the extreme poverty rate at 23.8 percent (World Bank). Haiti is also one of the most unequal countries in terms of income distribution (World Bank).

The relationship between poverty and health is evident. Poverty creates ill health by reducing access to clean water, sanitation, and safe shelter. This living environment breeds sickness and the spread of disease. Poverty exacerbates hunger, affecting people's nutritional levels, and reducing opportunities such as education and the ability to access healthcare facilities and moderately priced medicines.

A cycle of poverty is created. With sickness spreading in impoverished areas, households must spend their modest incomes on healthcare, reducing the ability to invest in a higher quality of life. The risks that the poor are exposed to from their living conditions makes them more likely to become sick themselves. Malnutrition exacerbates these sicknesses and the cost of healthcare is exorbitant for the standard of living (Peragallo 45).

### **Continuum of Care**

Continuum of care is highlighted as the third key component affecting maternal mortality and maternal health in Haiti. The continuum of care for reproductive, maternal, newborn, and child health (RMNCH) incorporates integrated service delivery, or the distribution of basic resources that women depend upon (WHO). This includes care for mothers and children from pre-pregnancy to childbirth, the postnatal period immediately following birth, and early childhood of the baby (WHO). There are two dimensions involved in the continuum of care. The first, time, ensures that care is being given during all the stages of pre-pregnancy, pregnancy, childbirth, and the early days of the baby's life (WHO). The second, place, involves linking the different locations of care. To achieve the second dimension, health facilities, homes, and community centers must collaborate about health care plans to reduce maternal, newborn, and child deaths (WHO).

Continuum of care programs are an area within maternal health that is severely lacking in Haiti. The timing of care, during all necessary stages of maternal health, and the place of care, available within multiple sectors of the society, are missing. Implementing continuum of care programs is one of the most effective ways to improve maternal health. By incorporating multi-stage approaches to healthcare, possible complications and risk factors are addressed early in the pregnancy, an adequate delivery location is determined, and the resources for all of these programs are known and coordinated. These health interventions are low cost and have massive potential life saving capabilities.

A continuum of care requires an extensive network of healthcare resources, affordable care, and accessible facilities. It is suggested that to address this, we must

improve the availability of services and road conditions. Prenatal and postnatal care must be incorporated, in addition to family planning services. Local health care workers, traditional and nontraditional, and the community members must be connected. An intricate network of health care must be formed that addresses the issues of access.

After looking at the different development history in Haiti involving maternal health issues and the key factors that the literature deemed important in looking at maternal health, these topics were explored further in my field study in Haiti.

## **V. FIELD STUDY**

In March 2015, I conducted a qualitative field study which investigated Haitian women's most pressing health needs, barriers to meeting those needs and proposed solutions, and how they perceive the community and outside organizations should be involved in addressing their needs. The study addressed development and clinic workers' view on the most effective methods for combatting issues of maternal health and how they think community and outside organizations should be involved in addressing these needs.

The impetus for this study was to further analyze the key issues of maternal health in Haiti: poverty, access to healthcare, and continuum of care through gaining a better understanding of the community perspectives on these issues. I also wished to address discrepancies between development literature and current practices within Haiti. Thus, my main research question was: how has international aid and development work affected the maternal health in Haiti and what should be done differently to produce more effective maternal health outcomes in this region?

## **Methodology**

The literature review looked at the key maternal health factors: access to healthcare, poverty, and continuum of care. Within these categories, multiple barriers to care were identified, including financial and geographic limitations.

A brief individual and group interview script was prepared to collect demographic information, current access to care, and important health needs. Local field staff translated the questions from English to Creole and then back to English.

I organized interviews with pregnant women in Acul Samedi, a rural village in northeastern Haiti, and Port-au-Prince, the capital of Haiti. Participants of this study needed to be female, Haitian, 18 years or older, mother of at least one child or pregnant, and Creole speaking. I conducted individual interviews with nine pregnant women or mothers in Acul Samedi. A focus group discussion was also conducted with twelve women in -au-Prince.

Additionally, I organized interviews with development workers that work in Haiti on maternal health issues. Participants of this study needed to have worked in Haiti or other developing nations on health related issues for at least 5 years, and be English or Creole speaking. There was no preference of gender or age (must be 18+ though). Seven individual interviews were conducted with key leaders of development or aid work in Haiti.

The Haitian women participants were recruited on a volunteer basis from local clinics in both Acul Samedi and Port-au-Prince. In Acul Samedi, Jeanne De Beleyr, the founder and executive director of the foundation Ti Soléy Leve, a community education organization, arranged the interviews with pregnant women and mothers through the local dispensary. Working with the head clinician at the dispensary, they asked for volunteers to participate in the study. In Port-au-Prince, women were interviewed out of the Delmas clinic supported by

the St. Jude Parish of Delmas. Father Andrew, the pastor of the parish, arranged the focus group with the head clinician by asking for volunteers from the maternal health program.

I recruited the development and aid workers through phone or email based on the NGO they work for and the maternal health programs that this organization provides. It was voluntary to participate in any of these interviews and the participant had the full right to withdraw at any time without consequences of any kind of loss of benefits to which they are otherwise entitled. All information is unidentifiable.

## **Field Study with Haitian Women**

### **Port-au-Prince**

#### Background

Port-au-Prince is the capital and largest city in Haiti. The city is built like an amphitheater around the coast, with the commercial districts near the coast and the residential regions in the surrounding hills. The total population is 3.7 million, half of the country's national population (Kovas-Bernat 24). Port-au-Prince is the center of all political and intellectual life in the country. For this reason, the highest concentrations of healthcare facilities are located in this area.

#### Interview Site

Interviews with Haitian women in Port-au-Prince took place in the St. Jude Clinic in Delmas, an area where much of the city's commercial and industrial enterprises are located. The clinic where the interviews were conducted is run through the St. Jude Catholic Parish.



One doctor currently works at the clinic three times a week. The focus of the clinic is on primary care. Their maternal health program focuses on pre-natal and post-natal care. The day-to-day operations of the clinic are supported through local fundraisers and the profits from clinic services. Only the salaries of the doctor and clinicians are funded through external fundraising by the parish.

Many women in the community of Delmas come to the St. Jude Clinic when they believe they may be pregnant. A pregnancy test is performed and if the result is positive, the woman is admitted into their pregnancy program if she chooses to. All of the women in the pregnancy program come to the clinic every month of the pregnancy for a consultation. These monthly records are kept, and the clinicians monitor any changes or potential complications. Ultrasounds are performed at each visit. Blood work and other tests are run to check for any potential risk factors or diseases. A small fee is asked of the women for the consultations and lab tests.

The St. Jude Clinic does not perform deliveries, but has a connection with delivery clinics all over Delmas and the larger Port-au-Prince area. As the delivery date approaches, the clinicians start discussing potential birthing facilities with the mother-to-be. The woman decides where to give birth and the St. Jude Clinic sends all of the consultation documents to the birthing facility to prepare the physicians for delivery. While the clinic stresses the importance of post-natal care, usually the women do not continue visiting the clinic if everything feels normal after the birth.

### Participant Characteristics

Twelve pregnant women who are patients of the St. Jude Clinic of Delmas participated in the focus group. The ages of the women ranged from 20-31. The mean age was 27. Three of the women were pregnant for the first time, while the rest had been pregnant previously. No complications had been cited in any of the previous or current pregnancies. Seven of the nine previous pregnancies were delivered at a delivery clinic, while the remaining two occurred at home with a traditional birthing attendant. For all women pregnant for the second or third time, there was a minimum of three years between pregnancies, with a maximum time between pregnancies of eight years. Three-fourths of the participants were married. All women interviewed had received a secondary level of education, or completed of high school. Five-sixths of the women were married. Half of the women had participated in family planning programs.

### Key Findings

Five important maternal health needs were identified in the focus group, ranging in order of importance. The most commonly mentioned need was money to prepare for the pregnancy, birth, and postnatal period. This directly relates to the second most frequently cited health need: nutritious food and drink for the baby during infancy and early childhood. Following this, the women believed that caring and attentive physicians were necessary. This involved seeing a physician that would consult with them about the pregnancy, birth, and post-delivery period to help the mother understand what to expect and how to be better prepared. The quality of care was cited as another key maternal health priority. While the women had physical access to private and public clinics, the financial need made it difficult

to receive top quality care. The quality of public clinics was not good, but this was often the only affordable care. Lastly, the focus group believed that proper treatment and attention in facilities must be improved upon. While this was mentioned as an overall need, the group focused specifically on the need to improve the care given in public hospitals. Experience in these hospitals was often marked by receiving inappropriate treatment, excessive waiting time to see a physician, and limited medical attention.

Participants in the focus group cited two key reasons for not seeking out healthcare: money and access to facilities. Inadequate funds would prevent the women from accessing care. While the majority of the women did not have issues finding healthcare facilities, some mentioned difficulty finding a clinic they were satisfied with. Participants did not have extensive personal experience with difficulties of access to facilities. Instead, they mentioned friends living in rural or remote provinces who did not see doctors because of a lack of money. Lack of education on the importance of maternal health was also cited as a key barrier to seeking out care.

When asked how the maternal health care in -au-Prince could be improved, the group stressed the need for more physicians, more health care workers, and more competent workers that could help them with all aspects of pregnancy and motherhood. It was emphasized that while they all lived close to the clinic, they knew this was an issue in other areas of the city. The group felt that the government had a responsibility to improve their healthcare in this way and must be held responsible to this.

## Discussion

The focus group in Port-au-Prince confirmed that poverty, access to care, and continuum of care are extremely important factors to address when attempting to improve the maternal health status in the capital. In addition to this, quality of care was stressed as another significant element to include in the maternal health discussion of the capital.

The inability to pay for quality healthcare services was cited as the key impediment to improving maternal health in the city. This directly relates to the poverty level of the country and the access to healthcare services. Quality care is still inaccessible to the majority of the population for financial reasons. While continuum of care programs exist, it is unaffordable to attend these facilities and receive the necessary care.

While these are key issues to be addressed in Port-au-Prince, it was found that the general level of maternal health and maternal health education is significantly greater than in other areas of the country. The women interviewed were aware of the many options they had for family planning, parenthood education programs, and clinic accessibility. The women were able to make well-informed decisions about their maternal health to ensure a safe and healthy pregnancy. A plan was set in motion to ensure the success of the birth and postnatal period. Healthcare facilities were collaborating as needed with their services and the community was trusting and satisfied with the care received at these locations.

## **Acul Samedi**

### Background

Sitting at the end of a long and heavily rutted dirt road, Acul Samedi is typical of rural villages in the northeastern region of Haiti. The small village is located outside of Fort-Liberte, bordering the Dominican Republic. The village population of approximately 17,000 is considered an outpost for the larger cities since it is an outlying settlement. Remote and poor, set in a mountainous terrain, Acul Samedi lacks many of the services found in Haiti's bigger cities, such as Port-au-Prince, Delmas, Carrefour, and Cap-Haitian.

The village has several primary and two secondary schools, located in buildings bursting with children in blue-and-white checkered uniforms. While the children are in school, the small populations of workers travel to neighboring farms in the mountains, markets, and development projects or factories outside of the village. Many of the men of the village travel to the Dominican Republic for work.

The maternal healthcare in Acul Samedi is typical of the rural, mountainous areas of Haiti. It is normal for women to give birth at home with the presence of a midwife. In the village, there are three well-respected and commonly used midwives. Fifteen years ago, it was customary for the midwives to connect with the local dispensary to get birthing materials. These materials included a knife for cutting the umbilical cord, antiseptic, a birthing mat, and a towel. The dispensary no longer offers these boxes.

When the woman goes into labor, the midwife is called to the home. If the birth goes smoothly, the midwife is paid and the woman is left to the care of her mother and grandmother. If there are complications, the family must find the funds and transportation to

bring the woman to the closest hospital, in Ft. Liberte. The final location of the delivery is where the funds are paid. Therefore, the midwife would receive no compensation if the delivery occurred at the hospital. As a result, many emergency services are delayed so that the midwife may complete the delivery. The women in Acul Samedi wait two weeks to name the child after delivery, in case the baby does not survive.

### Interview Site

Interviews in Acul Samedi were conducted at the local dispensary. This dispensary is a public facility operated through the Ministry of Health with help from USAID. One nurse and one administrative assistant are employed at the dispensary.

As is normal through public healthcare systems in Haiti, when a pregnant woman makes contact with the local healthcare center, the woman is issued a card noting every month that she should have a consultation with the healthcare provider. At the dispensary in Acul Samedi, the card is issued and the woman is told to go to Ft. Liberte, the larger neighboring city, to receive lab work and a sonogram they have to pay for. Many of the women do not receive any testing because they cannot afford to pay.

However, the women in the village continue visiting the dispensary for monthly consultations. At each consultation, a report is made noting the status of the pregnancy. The administrative assistant takes down maternal health history of the woman and determines any potential risk factors for the mother. Once a month, the dispensary sends the consultation reports to the Department, Nord-Est.

As a rural and impoverished village, there are many challenges faced in addressing the maternal health issues present. Without adequate facilities to test for complications of the

pregnancy, the dispensary is vigilant about looking at risk factors of the mother. The pregnancy is considered risky if the woman is under seventeen or older than 35, if the woman has more than five children, if the last child came too soon after the first (less than two years between them), if the last baby was less than five pounds, if the last child died during birth or very soon after, if a lot of blood was lost during the last birth, and if during the last birth there were complications. In addition to this, if the woman seems very pale and/ or tired, if she is very short (less than 1.45 meters), if she is less than 99 pounds or more than 170 pounds, or if she has tuberculosis, heart problems, or diabetes, she is considered at risk. These factors are noted at every visit and sent to the department each month to help plan for the potential complications.

The dispensary has delivery capabilities. While there are instances of women delivering at the dispensary, it is more common in the community to have home births attended by a midwife. If the delivery occurs at the dispensary and there are complications the dispensary will send the patient to the department hospital in Ft. Liberte.

### Participant Characteristics

Nine women were individually interviewed at the dispensary in Acul Samedi. This particular day was the designated time of the week where monthly pregnancy consultations occur. Of the nine women present at the dispensary, three were pregnant. All three pregnant women were three months pregnant. The ages of the women were 17, 19, and 34. It was the first pregnancy of the younger women and the second for the older woman. The older woman was married, with her husband living in the Dominican Republic. She gave birth with a midwife in her home for her previous birth, and there were no complications. The

other two women knew who the fathers of the babies were, but the men had not been involved in the pregnancy since conception. One of the women was pregnant from her first time experimenting with sexual intercourse. The other said it was an unplanned pregnancy.

The six non-pregnant women at the clinic varied in age from thirty to fifty-two. Four of the six women were at the dispensary to receive their shot for family planning. They had all had children before and decided it was a smart financial and personal decision to start the family planning program. The other two women were older and visiting the dispensary for hypertension. One had only had one child. The other had one child, but had many complications and became infertile after an emergency surgery during the first birth.

### Key Findings

Throughout the time spent in Acul Samedi during the discussions with women in the dispensary, the perceptions of health, particularly of pregnancy, were seen in a two dimensional way. All health decisions were made based on the present moment, without thought or discussion about future needs. When the woman becomes pregnant, she decides to go to the dispensary and get a consultation. When her water breaks, she seeks out the local midwife. If there are complications, she attempts to collect funds and organize the logistics to travel to an adequate hospital facility. The health decisions are made based on the current needs of the mother or baby without regard for any planning or preparation for the future.

Societal perceptions of reproductive health in Acul Samedi account for many of the challenges faced by women in the community. Sexual education is not taught or emphasized. Instead, children learn about reproductive health by experimenting with others. This



typically begins around the age of 13-15. Safety precautions are not fully understood and are uncommonly used because of the lack of education in this area.

Condoms are seen negatively in Acul Samedi. It is seen as offensive on the part of both parties to ask a partner to use a condom because it is perceived as signifying that the person is sexually promiscuous and would like to have many other partners. For this reason, condoms are seldom used.

The community of Acul Samedi strictly adheres to norms that stigmatize particular aspects of relationships and pregnancy. When the woman of a partner does not become pregnant frequently, approximately once a year, people in the village begin to challenge the relationship. If pregnancy is not occurring frequently, the people perceive the relationship as unsuccessful. Lack of pregnancy is believed to mean the couple is no longer having sexual intercourse, the man is sleeping with other women, one of the partners is not able to perform, or one of the partners is infertile.

### Discussion

The maternal health status in Acul Samedi corresponded with the literature on rural, mountainous areas of Haiti. The key impediments to care are the same three points mentioned in the research regarding maternal health: the level of poverty, the access to healthcare, and continuum of care needs. The additional component of quality of care was stressed as another necessary factor affecting maternal health in Acul Samedi.

Acul Samedi is extremely impoverished. Basic necessities are lacking. For this reason, people live a subsistence-based lifestyle. People are not afforded the ability to think in a three-dimensional or progressive way regarding healthcare decisions. Transportation,

finances, and facility access are not organized until the care is deemed essential. This accounts for many of the unplanned or unorganized accounts of healthcare planning in Acul Samedi. This situation creates an environment of unpreparedness for medical emergencies. This results in many unnecessary deaths and complications for the mother and child involved.

In addition to this, the community's perception of the maternal and reproductive health care issues constitutes another aspect of the maternal health situation in Acul Samedi. The community did not have access to the necessary materials needed to make well-informed health decisions. Family planning, parenthood education, and reproductive healthcare education were not incorporated into the everyday social structure of the community.

### **Field Study with Development Practitioners**

#### Background

In order to examine the effectiveness of this aid work and its relevance to the maternal health issues addressed through the literature review and field study, interviews were performed with key individuals in various development and aid organizations.

#### Participant Characteristics

Seven individuals were interviewed, ranging in position and type of organization to adequately represent the different interest groups currently working on maternal health issues in Haiti. The organizations were USAID, LiveBeyond, Profamil, Children's Nutrition Program of Haiti, Global Health Action, the Catholic Parish in Delmas, and Ti Soléy Leve.

USAID is the lead U.S. government agency “that works to end extreme global poverty and enable resilient, democratic societies to realize their potential” (USAID).

USAID funds 164 health facilities throughout Haiti, ranging among dispensaries, clinics, and hospitals. USAID works directly with the Haitian federal government and Ministry of Health.

LiveBeyond is a faith-based, humanitarian organization that brings clean water, medical and maternal healthcare, community development, and orphan care to the people of Thomazeau, Haiti.

Profamil is the leading provider of sexual and reproductive healthcare in Haiti. They are partnered with the International Planned Parenthood organization, and provide nearly 265,000 services throughout the country. The services are delivered through their four clinics and mobile health unit that provides basic care in rural areas.

The Children’s Nutrition Program of Haiti, or CNP, works in Leogane, Haiti to bring healthcare, nutrition, and education to the area. This is pursued through their Outpatient Therapeutic Food Program, Supplemental Food Program, Preventative Care Programs, Women’s Empowerment Groups, and Community Based Microenterprise work.

Global Health Action works in rural Haiti, specifically Darbonne and Leogane, with a mission to “improve the health and well-being of individuals and communities in under-served parts of the world through community-based health programs and livelihood opportunities” (“Programs in Haiti”). This is achieved through training and equipping local health professionals, community health workers, traditional birth attendants, animal health workers, and goat farmers to meet the currently faced challenges at their source using culturally-appropriate methods and locally-available materials and supplies.

The St. Jude Catholic Parish in Delmas, Port-au-Prince has been established since the 1950's. This parish operates a church, a local recycling program, an adult literacy program, a clinic, and community outreach events. The parish partners with the Mother Teresa's Orphanage as well.

Ti Soléy Leve is an educational training and documentation center founded in 1988 in the village of Acul Samedi. The three main objectives of Ti Soléy Leve are to provide education for every child with pedagogically sound material, to create a sustainable environment in which the community is able to meet local needs and fight for conservation and community development, and to ensure a right to healthcare for the community by supporting the local dispensaries in their actions on health care for mothers and children, family planning, and emergency response to extreme hunger.

### Key Findings

Interviews with development practitioners in maternal health confirmed the major issues were poverty, access of care, and the continuum of care. The additional maternal health needs of competent medical staff and family planning and counseling were also cited as important factors to address.

The access to facilities was cited as a key concern by all interviewed. While there are many concentrated services in Port-au-Prince, there are not enough services outside of the city. Community health centers are sparse or nonexistent. In the mountainous areas, women must walk long distances to find an adequate health center. Even when services are found, many facilities lack trained doctors or adequate staffing.

Trained birthing attendants and quality medical staff are a rarity in many health facilities in Haiti. The level of service at these facilities is often subpar, as many important procedures cannot be performed safely or adequately. Hygiene and other educational components about delivery are lacking in the training of many midwives. Supplies are also often lacking.

Many of the development practitioners cited a key concern to maternal health issues in Haiti to be the lack of continuum of care programs. While many women would seek medical care during the initial phases of the pregnancy, for various reasons prenatal and postnatal care was often used inconsistently or not at all. Lack of education about the importance of continuum of care and the inability to afford such care were the cited reasons for not seeking out additional care.

Interviewees believed that many of the problems associated with maternal health stem from poverty and the different challenges this creates. Malnutrition, tuberculosis, diarrhea, cholera, and other preventable health problems add increased stress and risk to the pregnancies. Vaccine use is not widespread or affordable.

In order to better prepare families to make educated decisions about their reproductive future, family planning and counseling was stressed as a key need for maternal health issues in Haiti. Many women do not have the ability to make decisions about their sexual relations, and family planning would at least allow them to decide if they become pregnant or not. In addition to this, educational programs would allow young men and women better prepare themselves for the challenges and responsibilities that sexual relations and parenthood brings.

*Greatest Barriers to Addressing these Needs*

The greatest barriers to addressing these maternal health needs were cited as funding, political instability, and the national healthcare system. Funding for clinics, hospitals, and healthcare workers was mentioned as a key barrier to addressing maternal health needs in Haiti. The facilities that exist are not able to operate at their full capacity because of lacking funds. In addition to this, the women seeking care cannot afford the travel or medical funds necessary to receive care. Whenever there is political instability or foreign interventions, the ministry of health faces increasing changes and challenges. The country's healthcare goals and projects constantly have to adapt to the new conditions, reducing their effectiveness greatly.

The national healthcare system is not currently well-regulated, focused, or organized, according to four of the people interviewed. This creates immense difficulties for the country to offer a uniform level of care. One of the biggest issues with the healthcare system was cited as the national drug distribution. Regulation and storage of drugs is a major issue. In addition to this, the Haitian healthcare budget has not had adequate funds to pay salaries for the amount of healthcare workers needed. The Haitian budget does not provide funding for health insurance or reproductive health education in schools, key programs that could improve the quality of maternal healthcare in Haiti. There are no required community healthcare education programs through the government either.

*Best Solutions to Address these Needs*

The best solutions to addressing the maternal health needs in Haiti, as defined by the seven development practitioners interviewed, are increasing the access to healthcare in Haiti,

empowering the community, and education. It is crucial to note that this differs from the literature review, which did not discuss empowerment or education.

Improving the health infrastructure was cited as one of the key ways to improve the maternal health condition in Haiti. This involves increasing the facilities outside of the Port-au-Prince. In addition to this, it would involve increasing the connections between clinics, doctors' offices, hospitals, and community health centers and creating physical connections between the healthcare centers, or ensuring that there are adequate roads. This also means that the healthcare facilities are in constant communication to improve the services offered and coordinate all activities.

Empowering the community to make healthcare decisions was seen as a crucial area to improve maternal health. This involves guaranteeing that the community health workers, members of the community who are chosen by community members or organization to provide basic health and medical care to the community, have the knowledge, skills, and commodities necessary to address the maternal health condition in their area and provide the appropriate care to their patients. It also means ensuring that the community members have the resources and tools needed to make educated decisions about their healthcare and the health system of the community. The environment of the community must be such that their health needs are addressed and prioritized.

Health education throughout Haiti was cited as a crucial component to improving the maternal health status of the country. Family planning programs and reproductive health education are especially necessary to incorporate into the larger education system of Haiti. By incorporating these services, behavior change related to reproductive health and parenthood could occur. Vaccination and nutrition would also be emphasized in order to

provide a comprehensive approach to the many opportunities to reduce infant and mother death.

*Role of Different Groups in the overall Maternal Health Paradigm*

Development practitioners interviewed felt that it was the role of the Ministry of Health to enact all healthcare policy, rules, and regulations. The government should subsidize care so it is affordable and of high quality. This also involves actively distributing vaccines, collecting healthcare data, coordinating the activities of all health-related NGOs, and providing reports on the status of different health conditions. Public education and healthcare training would come through the Ministry of Health as well. Building the government's capacity was seen as the way to effectively create accountable and sustainable change in the healthcare field of the country.

Discussion

The discussion of key maternal health issues by development workers from various organizations demonstrates the commonalities found in the healthcare focused groups within Haiti. While there were differences of opinion related to the most pressing maternal health need or how best to improve upon existing health care in Haiti, there is agreement about who should lead all healthcare initiatives and what key components must be involved in these projects.



## VI. CONCLUSION AND RECCOMENDATIONS

After completing the qualitative research study, I have concluded that the literature review accurately reflects the development beliefs of on-the-ground NGOs conducting maternal health projects in Haiti currently. These organizations are attempting to incorporate community-led development through “accompanying the intended beneficiaries” in all projects (Sculler xi). This follows the alternative development belief that changing the methods of development to a participatory model is needed to improve the effectiveness of development projects. By working alongside the communities in Haiti in all maternal health projects, the NGOs exhibited this model of participatory development. Even with these commonalities found between the literature and on-the-ground work, though, I found that there were key aspects of the maternal health status in Haiti that were being overlooked within this development discourse.

The first aspect of development work in Haiti that is not being addressed in the current maternal health programs is the coordination of the activities of the different groups working on these issues. With so many different organizations doing work on maternal health issues, it is difficult to measure the effectiveness of any one organization. I propose, therefore, that in order to adequately address the maternal health condition in Haiti, the many different groups involved must work together under an organized plan in order to cover all the necessary aspects of care and to address these issues in all areas of the country. This will improve the effectiveness of each organization, as they will be able to specialize in their skills and educate others about their unique attributes. The plan will allow the development workers to analyze their programs to determine which are or are not working and how to improve them.

Additionally, development workers need to incorporate a more holistic vision of the maternal health situation in Haiti. Thinking that the maternal health status in Haiti is a problem that can be dealt with through only one perspective is detrimental to the issue. There are many factors at work that affect the maternal health status in Haiti and these organizations must consider the interconnectedness of these in all of their work. This involves looking at the social structure, cultural norms, perceptions of health, quality of facilities, and more. There is the huge issue of not actually looking at the anthropological factors that affect the overall status of maternal health care in Haiti. There are many social stigmas associated with reproductive health. It is incredibly important to consider these factors and truly understand them before doing any sort of development work.

While I believe incorporating these changes into this alternative development model could greatly improve its efficacy, I do not believe development workers have adequately questioned what “community-led development” looks like or addressed the concerns of the development discourse that the entire notion of development is at the root of its ineffectiveness.

Through anecdotal and personal experience, I have found that the definition of “community-led development” varies greatly between organizations. In many cases this means that the maternal health projects enacted are based on Western ideas of health. The Haitian community is then “included” in the projects by working as assistants or clinic workers. This does not mean that the community had any say in the decision making or planning processes of the projects. This perception sees the “outsider’s” ideas as the most advanced or developed, and the ideas of the community as inadequate. I do not believe this is truly community-led development.

For this reason, I find it necessary to evaluate the development discourse we have created. Development creates a world of binary oppositions between the “developed” and the “underdeveloped” in which economic progress is viewed as the measure for success (Esteva 10). The goal of mainstream development to improve well-being, or income, is applied equally throughout the world. This goal is still embedded in the alternative development theory previously mentioned. The development workers interviewed use this as the goal in all of their maternal health programs. They believe this increase of income will provide the ability for women to access food and water, health care services, and other necessary goods to improve the maternal health situation in Haiti. The only issue the development workers have with the current model is the methods in which this goal is emphasized, which is why they focus on creating new and community-focused development.

I argue that changing the methods of development does not truly address the problem of the poor maternal health status in Haiti. Currently, progress is only measured in terms of market values and the positive material side of development. This creates a societal focus of egoism, competition, and obsessive performance as communities are forced to align with capitalist ideals to have a share in the global economy (McMichael 295). Consequently, this emphasis on Western ideals has caused homogenization and monoculture around the world. This development discourse prevents creativity and diversity in solving problems because it takes agency out of the system. Communities lose the ability to act independently and make their own free choices.

Instead, I maintain that a redefinition of success (“development”) provides a space in which maternal health in Haiti can truly improve. This alternative development mentality

believes that for every place, the goals of development and means to achieve it will be different. This means the relationships with “outsiders” would vary from community to community as they see fit. This is the beauty of this theory, it adapts and transforms depending on the needs of the place. This alternative development focuses on a pluriverse, localization ontology, seeing a world in which many worlds are possible. In Haiti, this would mean that instead of focusing on improving the material wealth of the country in hopes of it bettering the maternal health, the community could decide how best to improve their health. This could involve pursuing more traditional medicinal practices, empowering local leaders to be community health workers, or creating a training program for pregnant women. Instead of having growth signify an accumulation of goods, the Haitians could look at social transformation and human development as the measurement of progress. By emphasizing these values, the focus of success shifts to altruism, cooperation, and leisure among many other possibilities (McMichael 295). To truly have community-led development, the people need to be able to decide what this development looks like and how to prioritize their maternal health needs.

This will vary in every location, but one example of a successful community-led “development” project was enacted through the Children’s Nutrition Programme of Haiti. The leaders of this organization traveled to Haiti to look at the acute malnutrition needs. They found that in every small community, one woman’s children maintained a higher level of health than the surrounding children. Through this they found that the community already had the resources and knowledge to improve the health condition. The organization then spoke with the community to see if there were any needs they were hoping to improve. The community focused on malnutrition. Through this collaboration, the community and

Children's Nutrition Programme of Haiti developed a program for training women in the community to learn how this mother was improving her child's health. These women became trained community nutrition workers called monitrices and held programs to educate their own village about improving the health status. The "outsider" organization's only role was to help support the program and provide expert advice or health training as the community asked for it. Since this program has been enacted, the health status of the villages has greatly improved. This example of community led development looks at non-market values as the measure of progress. The community decided how they wanted to improve their situation and how to best go about this. This is alternative development in action improving maternal health in Haiti.

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