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Beyond the Three Delays: A Case Study of Haiti's Maternal Health Sector

Stephanie Rapp
SIT Graduation Institute, stephanie.rapp@mail.sit.edu

BEYOND THE THREE DELAYS:

A CASE STUDY OF HAITI'S MATERNAL HEALTH SECTOR

Stephanie Rapp

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Advisor: Rachel Slocum

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Student name: Stephanie Rapp

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1. Abstract

This research seeks to understand how the maternal health sector in Haiti can be understood and perhaps improved through the framework of the Three Delays, developed by Thaddeus and Maine (1994). These delays are (1) the delay in the decision to seek care, (2) the delay in reaching a health facility, and (3) the delay in receiving adequate care at a health facility. The findings of this capstone strongly demonstrated that global health practitioners in Haiti often opt for technical solutions, but in fact there are numerous shadow delays preventing these solutions from taking hold and ameliorating maternal mortality. Tensions between government actors, NGOs, healthcare workers and receivers of care play out in a landscape of imbalanced resources. Efforts lack collaboration and recognition of historical pain felt by Haitians at all levels of society, and NGO stakeholders are frequently oblivious to these dynamics. The research found that Haiti sits at the intersection of global health priorities, local histories of resistance, NGO strategies of community health, and public institutional development. Many argue that care should be socialized, subsidized and public, while others admonish the government and advocate for privatized approaches more attuned to local needs. Approaches to maternal mortality must be both collaborative, inside and outside formal institutions, and take a broad view of of the barriers to healthcare and safe birth for women in Haiti, not just in the form of the Three Delays, but in the socio-political histories that dispossess key stakeholders from taking appropriate action.

2. Introduction

The short film, "Why Did Mrs. X Die?", made in 2012 by the World Health Organization (WHO) tells the story of an anonymous woman, Mrs. X, who died of a hemorrhage during childbirth in a small hospital. Her story is meant to illustrate maternal mortality as a global, preventable problem and start a discussion on how global health advocates can make changes to the to the maternal health sector. Mrs. X is described as a universal mother, her context as it is presented in the film is reminiscent of rural Haiti, where I have been working for the last 11 months. The maternal mortality rate in Haiti was last estimated to be 380 deaths per 100,000 births and only an estimated 10% of the need for maternal care is being met by available healthcare workers (WHO, 2014, p. 110). My capstone seeks to understand the stakeholders and actors involved in story of Mrs. X as they exist Haiti, the strategies they adopt, the progress they have made, and the confines within which they operate.

While Mrs. X's file is initially put away without much attention, the film progresses to show the administration of the hospital revisiting the case and determining the protocols and procedures to change to avoid similar deaths in the future. They conclude that the hospital will need a better blood bank, and better resources for Caesarian sections. In the film, these improvements are made quickly and without pushback or complications. Then, the film depicts a group from the regional government coming to Mrs. X's village to investigate the social determinants of her death: that is, "conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life" (WHO, 2016). According to the story, Mrs. X did not have access to education, family planning services, or prenatal care with a midwife, doctor, or nurse. Throughout her life, she had been excluded and denied basic needs as a result of her gender and did not understand that bleeding during her

pregnancy was a danger sign. Furthermore, her community took six hours to collect the funds to transport her to the hospital after her condition was discovered. The film ends with the missive: Mrs. X did not just die of a hemorrhage, she died of social injustice.

"Why did Mrs. X die?" fits well with Thaddeus and Maine's "Too Far to Walk: Maternal Mortality in Context" (1994). In this article the authors propose that maternal deaths can be attributed to Three Delays, a theory they developed from a comprehensive review of literature on worldwide maternal mortality. Thaddeus and Maine determined that there were three reasons a woman might die unnecessarily in childbirth. She could experience:

1) A "delay in deciding to seek care on the part of the individual, the family, or both" (p. 1092). Mrs. X did not understand the severity of her bleeding, and did not have an opportunity to realize the importance of prenatal care. She did not have autonomy over her health.
2) A "delay in reaching an effective health care facility" (p. 1092). Mrs. X was unable to obtain transportation to the hospital for six hours.
3) A "delay in receiving adequate care at the facility" (p. 1092). When Mrs. X arrived at the hospital, she did not receive sufficient blood and was taken into surgery too late.

Mrs. X is described as any woman, anywhere in the world. Any woman, anywhere, can die in pregnancy as a result of obstetric complications. But in the film, Mrs. X is said to be mostly likely from a poor village in poor country. She is depicted as a woman in non-Western dress and living in a home with a grass roof. There is universality to her story, but it is rooted in the idea that maternal mortality is higher in the Global South than other regions. Thaddeus and Maine also do not argue that their model is totally universal, but do hold that it is applicable to maternal health sectors in both the Global North and Global South:

> Maternal death in areas where distances to health facilities are large and services poor are comparable to maternal deaths in New York City, where a woman many live next door to a high technology hospital but still die because of poverty and its attendant impact on the decision to seek care (p. 1092). [1]

The framework of the Three Delays can be applied to almost any health emergency. Regardless of our context and environment, we may delay our decision to seek care, may experience difficulty finding a ride, and may encounter a doctor or nurse who makes a poor diagnosis. The story of Mrs. X reminds us that in the Global South, these delays are particularly impactful. Where economic resources are scarce, popular health knowledge is limited, roads are poor, and health systems are weak, obstetric emergencies can very easily result in death.

My thoughts around maternal mortality and the Three Delays have developed over the past year in my practicum position with the U.S.-based 501(c)3 organization Midwives for Haiti (MFH). MFH has operated for nearly 10 years in Hinche, Haiti and has five key programs: a one-year training program for Haitian nurses to become skilled birth attendants (SBAs), a mobile clinic which visits 22 sites in rural Haiti monthly, an outreach initiative with traditional birth attendants (TBAs), or *matwòns* as they are know in Creole, a rural birth center (referred to as the CWBC), and finally, a partnership with the maternity ward of the nearby Hospital St. Thérèse run by Haiti's Ministry of Public Health and Population (MSPP). The hospital was built in 1925 during the U.S. Occupation of Haiti, which stretched from 1915 to 1934. Working as the Director

[1] A similar idea is espoused in the film *No Woman No Cry* (Turlington Burns & McCarty, 2011). A woman in Tanzania may have enormous trouble reaching a health facility, but when she does, she will likely receive care for free. Yet in the United States, where providers are plentiful, a woman may not be able to afford care without generous health insurance.

of Programs and Partnerships at this multifaceted NGO has given me a front-row seat to the dynamics and realities of Haiti's maternal health sector.

I began exploring approaches to maternal health while examining the relationship between MSPP and MFH as it plays out in Hospital St. Thérèse. This partnership is complicated, and echoes many of the problematic dynamics that exist throughout Haiti in areas where non-governmental organizations (NGOs) dominate social services. Haiti is commonly referred to as a "Republic of NGOs," and is thought to have about 10,000 operating nationally (Archer & Le, 2013), many of which are not formally recognized by or in partnership with the Haitian government. In *Building Partnerships in the Americas*, Archer and Le argue that "the presence of so many NGOs may actually hinder, not help development in Haiti because NGOs often are better than the Haitian government at attracting grant money from donors" (p. 195). I have seen the detrimental effects of this NGO-ization through my work experiences in both Port-au-Prince and Hinche.

Throughout this year, I have sought out examples of maternal healthcare approaches that would give context to MFH's work and perhaps provide alternatives for how maternal healthcare could be practiced. This search meant understanding as much as possible about maternal health in Haiti by capturing as much of the sector as I could access. In order to limit the scope of my study, I narrowed my research question to the following: How can the maternal health sector in Haiti be understood and perhaps improved through the framework of the Three Delays?

The findings from this study strongly demonstrated that these Three Delays are real and impactful in Haiti, but that there are also more complex factors at play. Practitioners in global maternal health often opt for technical solutions, but there are numerous shadow delays – in other words, delays not so visible as poor transportation or healthcare – that are preventing these

solutions from taking hold and ameliorating maternal mortality. The shadow delays can result from myriad sources: tensions between government actors, NGOs, healthcare workers and receivers of care unfold in a landscape of imbalanced resources; many efforts lack collaboration and recognition of historical pain felt by Haitians at all levels of society; NGO stakeholders in particular are frequently oblivious to these dynamics; and finally practices are often intensely formal in ways that alienate women, or so informal they are not able to function or collaborate effectively.

While the Three Delays are a very useful framework for understanding causes of maternal mortality, I argue that socio-political histories surrounding public health lengthen these delays and augment barriers to care. In order to adequately overcome these shadow delays, local, national, and international stakeholders must be willing to collaborate, hold each other accountable, and imagine alternative approaches that combine formal and informal structures.

In Section 3 of this paper, I review the literature relevant to Haiti's maternal health sector: texts that go beyond Thaddeus and Maine to explore the Three Delays as they effect women in Haiti, the realities of public health care in the Global South, and the politics and history that impacts development funding. Section 4 focuses on my research design, which included participant observation, interviews, numerous site visits to health facilities, and a survey. The research design section also details the limitations and personal subjectivity that influenced the study. I then report my findings in Section 5 and examine how they aligned with the 3rd, 2nd and 1st Delays. In Section 6, Discussion, I explore shadow delays and social, cultural, and historical influences on the maternal health sector. My recommendations for further practice are detailed in Section 7. I also used the opportunity to highlight a positive example of multi-stakeholder health initiative I was a part of with MFH this year.

3. Literature Review

There is a wide variety of research available on maternal mortality, the Three Delays, and health sector practices in Haiti and the Global South which grapples with how the health of women can be improved. This literature is engaged in debate around whether approaches should be technical, such as improved supply chains within hospitals, or social, such as trainings tackling classism between healthcare workers and patients. Other authors debate whether approaches should be grown locally through grassroots women's movements, or strategized globally through tools like the Sustainable Development Goals. Beyond this, conversations continue on whether childbirth should be handled with modern biomedical interventions, or whether traditional healing and home birth practices would be more effective in ensuring women's safety. Still more consider whether health care is best examined at the individual patient level or through the structures of large institutions.

Finally, I discovered through my own research that there is a subtler debate emerging on whether health priorities should be determined through public, government systems, or through communities. These discourses ask, by extension, who bears the responsibility for implementing these priorities. Notions of responsibility and participation are very relevant for Haiti, where services are privatized and disconnected. All of these debates inform the approaches and philosophies I have encountered in my research and will lay the groundwork for understanding the context and limitations in which maternal health is practiced in Haiti.

3.1 Individual and Institution

My research into the maternal health sector was located in the actions of health providers and systems, rather than individual decisions on how to access those approaches, and this makes

the Three Delays a tremendously useful framework. Thaddeus and Maine's article on the Three Delays was published in 1994. Their illustration of the Three Delays is below in Figure 1:

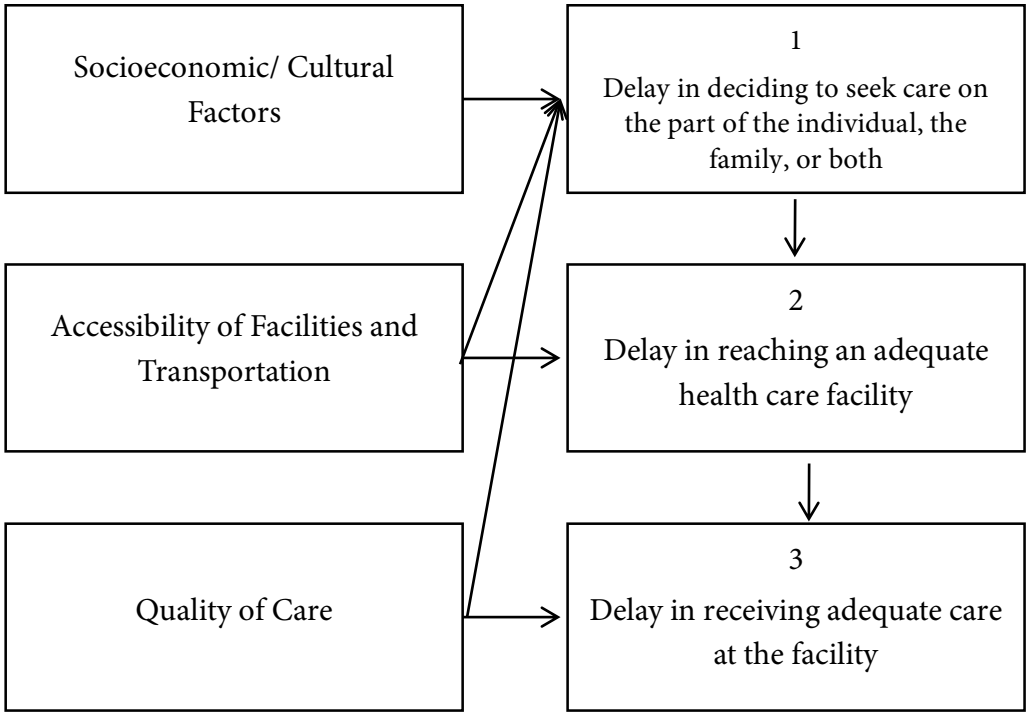

Figure 1: The Three Delays

Building upon this seminal, work, in 1998, Barnes-Josiah, Myntti, and Augustin wrote "The 'Three Delays' as a Framework for Examining Maternal Mortality in Haiti." The authors in these articles move the conversation about women's health away from individual behavior towards community and national challenges with poor access to health infrastructure.

Barnes-Josiah, et. al, identify 12 distinct cases of maternal mortality among a longitudinal cohort of pregnant Haitian women, using verbal autopsies given by family members to determine the series of events that lead to the woman's death, similar to the investigation into the death of Mrs. X. The authors determine that eight of the 12 deaths resulted because of the 1st delay, seven because of the 3rd delay, and two because of the 2nd delay, obviously noting that many of these women were impeded from receiving live-saving care by two or all three of the delays. While the

study illuminates many issues in the maternal health sector in Haiti, the most vital assertion is their last:

> While action on all three delays is important to reduce maternal mortality in Haiti, the third delay is perhaps the single most important: the benefits of obstetric care must be real. Investments in family and community education, in TBA training and referrals, or in improved transportation networks, are meaningless when women actually reach a hospital only to die there from non-existent or inadequate care. Haitian women will continue to under utilize existing, accessible medical centers if they perceive the serves to be incompetent, costly, unpleasant, or dangerous (p. 991).

This quote describes the flow of arrows in Figure 1. Factors leading to the 2nd and 3rd delays all inform and perpetuate the 1st.

Thaddeus and Maine instigated the conversation on delays in accessing care, with Barnes-Josiah et. al, bringing the conversation to Haiti and locate the main responsibility of obstetric care in the hands of formal institutions. In many ways, Barnes-Josiah et. al,'s is a more simplistic analysis than the case study of Mrs. X on the social determinants of health. Yet while Mrs. X asks us to look outside the hospital for causes of death, *Three Delays* reminds us to look back into institutional care and the social determinants that influence its effectiveness or ineffectiveness. My research seeks to understand not only whether or not these institutions adequately bear that responsibility 18 years later, but what prevents them from doing so and whether non-formal, non-institutional actors can also bear the responsibility.

More quantitative studies by Gage and Calixte (2006) and Babalola (2014) focus on the 1st and 2nd delays more in-depth. Babalola looks at a wide variety of individual level indicators that affect seeking care, while Gage and Calixte return to addressing the health infrastructure,

particularly physical accessibility, involved in maternal mortality. Both of these studies rely on data that differentiates women who seek prenatal care and a skilled birth attendant from those who do not, and Gage and Calixte in particular recognize that some of this care may be available to women outside of formal institutions, for example, through mobile clinics. Yet neither study, nor that of Barnes-Josiah, et. al, looks in detail at approaches across the maternal health sector on the part of the government or NGOs. When examining approaches, I will need to not only take into account institutional and non-institutional initiatives, but also seek to understand the intentions and socio-political implications of those doing the implementation.

3.2 Global and Local

Maternal health in Haiti exists as both a local and global phenomenon. Before easily assuming women to be uniformly poor, non-autonomous, Mrs. X-type receivers of health in Haiti, it is useful to engage Chandra Mohanty's *Under Western Eyes* (1984). In this essay, Mohanty posits that women in the Global South, or the 3rd world, as she refers to it, should not be analyzed and understood as a monolithic, universal category, yet argues this is a common trap that Western Feminists fall into when attempting to write about the oppression of women globally. Women are not an ethnographic unit created in isolation from a society, religion, or development plan that oppresses them. Instead, women are a group formed by society and thus not a "stable category of analysis" (p. 344). While we can make descriptive generalizations about women across cultures, we cannot then use those descriptions of practices to infer meaning, value, or oppression in those various societies.

Mohanty's analysis is worth using when examining NGOs focused on women and questioning which women receive attention and in what forms. Many NGOs in Haiti have a

tendency to focus on the poorest of the poor, in part guided by the work of Paul Farmer's "Preferential Option for the Poor" (discussed below). But Mohanty's global theories suggest that efforts like these in Haiti and the writing around them leads observers to believe there are only poor people in Haiti, and that women here are universally disadvantaged and unable to seek healthcare, or unwilling to do so for irrelevant, illogical reasons.

An indispensable and deeply specific exploration of women's health in Haiti is *Reproducing Inequities*: *Poverty and the Politics of Population in Haiti* by ethnographer Catherine Maternowska (2006). Maternowska's text examines a family planning clinic in the Port-au-Prince slum of Cité Soleil in the early 1990s that received significant international funding, but almost no clients. The clinic's approach was a manifestation of a belief that a reduction in fertility rates is a silver bullet to fight poverty and improve quality of lives in the Global South. International donors pushed for family planning as a vertical, technical intervention, using a view of macro social categories and demography to make decisions about poor women's lives. Maternowska argues that these actions did not take into account cultural and political survival strategies that persist in Haiti, and in Cité Soleil in particular, and did not recognize that healthcare, especially healthcare imposed by the U.S., is not neutral or technical, but political and prone to resistance.

Maternowska's theories, like Mohanty's, argue for complicating the macro view of women as a category to be understood with statistics and theorized patterns, avoiding "technical fixes that evade deeply political questions" (2006, p. 10). She suggests that on-the-ground views will result in better community-led development that take into account micro-level political, economic and cultural forces. But her theories also focus squarely on fertility and the behaviors around it. What happens to women when their pregnancies do go forward is left mostly out of

the story. Women's choices and agency are still Maternowska's central topic, rather than their survival.

3.3 Technical and Social

Beyond the Three Delays, it is also vital to engage literature on health in Haiti that contends with these divides between technical and social understandings of all forms of well-being and care. These distinct understandings are directing the actions of myriad healthcare stakeholders in Haiti and the degree to which they operate with ahistorical or historically-rooted practices. The most well-known and comprehensive studies of health in Haiti have been written by Paul Farmer, an infectious disease doctor, anthropologist, founder and strategist of the international NGO Partners in Health (PIH, known in Haiti as Zanmi Lasante, ZL), and leader in global health studies and medical anthropology. His texts *Pathologies of Power* (2003), *Infections and Inequalities* (1999), and *Aids and Accusations* (1992) look not only at the technical realities of caring for complex infectious diseases such as multi-drug resistant tuberculosis and HIV/AIDS in impoverished rural Haiti, but at the structural and political violence that underlies the glaring epidemiological divide between the Global North and the Global South.

In the Central Plateau of Haiti, where I have been working and observing for the past year, there is no theorist, practitioner, or writer who stands taller than Paul Farmer, particularly for those engaged in the work of healthcare. Today, Farmer advocates for the field of global public health to be reimagined entirely as the field of global health equity, wherein healthcare is not only provided to populations in need, but done so in the ethos of redistributing attention, wealth, and justice to those whom history has deliberately denied. Drawing from Latin American

leaders in Liberation Theology, Farmer calls this the "Preferential Option for the Poor" (2003, p. 139).

Yet the bulk of Farmer's writings on structural violence and healthcare inequalities in Haiti are confined to the 1990s and early 2000s, since which point much has changed in global health care priorities. Furthermore, Farmer's texts do not focus on women's health or maternal mortality, even though that programming exists within PIH/ZL operations, looking instead at the poor en masse and the disease their poverty makes them susceptible to, again, en masse. While my own understanding of health and inequality in Haiti has been informed tremendously by Farmer, and I feel that the work of PIH/ZL is instrumental in understanding public heath policy in Haiti, his contributions to an analysis of women's health and maternal health in particular are negligible. His work is worth engaging less for what it explains about Haitian realities than for how it has influenced healthcare praxis across Haiti in the area of my research.

Equally relevant to understanding the integration of the technical and social practices of medicine and disease in the Global South space is *Improvising Medicine* (2012) by Julie Livingston. Livingston immersed herself in the cancer ward of a public hospital in Gabarone, Bostwana in the late 2000s. Based on the observations of the behaviors of healthcare staff and cancer-afflicted populations, Livingston critiques the implications of treating such a chronic, complicated disease in a healthcare system unequipped to handle it. She explores how this treatment is conducted in the face of a global misconception that diseases such as cancer do not occur in the Global South. Livingstone writes that the funds and resources of the global health community are "deployed toward developing new drugs, techniques, and technologies, rather than toward expanding access or tailoring extant therapies and insights to suit African populations in need" (p. 31). Oncology in the Global North has consisted of high-technology

solutions tailored to individual cancers, rather than public health strategies with social community dynamics in mind. Livingston's work is not relevant to maternal health or Haiti per se, but her analysis helps to contextualize how technical responses to health issues are perceived, managed, and resisted amidst the inequalities and historical pain of the post-colonial Global South. *Improvising Medicine* lays important groundwork to understand the capacity, efficacy and limitations of formal biomedical institutions in Haiti.

In contrast to Maternowska's and Farmer's arguments for localized medical practices that address structural violence and inequities, Julie Freedman argues for technical fixes to address systemic inequalities, but fixes that need not adhere to rigid medical hierarchies. In her article "Shifting Visions: 'Delegation' Policies and the Building of a 'Rights-Based' Approach to Maternal Mortality" (2002), she links the strategy of task shifting to the Rights Based Approach (see Boesen and Martin, 2007), a theory of development which compels practitioners to address human rights and power relations, rather than giving charity, and once again asks for the initiators to focus on the poorest of the poor.

Freedman connects this focus on the most vulnerable women to her focus on emergency obstetric care (EmOC). She stresses that most EmOC interventions are low-tech and long established but remain inaccessible to the most vulnerable women due to bad management and weak public health systems. While high levels of medical knowledge in anesthesiology and surgery are needed to ensure the highest maternal survival rate in an emergency obstetric situation, this knowledge is only accessible in certain areas. Thus when lower levels of medical professionals (who are usually more equitably dispersed among the population) operate on a wider scale and are permitted to provide the same level of EmOC, the overall survival rate will increase. She lays out the following contrast:

> From the strictly clinical perspective, survival rate matters most: Looking at the abstract individual patient, the safest option is the anesthesiologist…. From a public health perspective, then, coverage matters most: Looking at the entire population in actual context, the biggest safety risk by far is the failure to reach the functioning health care system at all (p 155).

Freedman argues that the rights-based approach prioritizes less-skilled care in more places over highly skilled but rare opportunities for care, and stresses that this is a logistical and public system-level concern. In this way, Freedman places the technical before the social in an effort to advance a broader availability of care for women, ultimately a social goal. Task shifting and delegation of care are the foundation of many approaches examined in my research and demonstrate a choice to favor interventions that may take place within institutions but operate outside their formal hierarchies.

Maria Fannin views the global women's health through a more social, emotional, and interpersonal lens in "Global Midwifery and the Technologies of Emotion" (2006). She describes an emerging category of North American midwives and "natural" birth advocates who conceive of their practices as globally transferrable and transnationally relevant. Yet the mobility of these midwives through medical spaces results in the essentializing and simplifying of the practice of Othered, less global midwives from whom they can learn. Their engagement with midwives around the world still operates around a dichotomy of "who [is] situated as the bearer of traditional knowledge and who [holds] modern, scientific knowledge" (p. 81). In this, Fannin's writing echoes Mohanty's cautionary arguments against lumping women of the Global South into a simplified whole. Simplifications play out among foreign stakeholders and NGOs in Haiti,

often reducing their capacity to engage more complicated established public systems and perpetuating historical inequities between the Global North and South.

3.4 Public, Private, and Community

As noted in Section 2, my research question grew from my observations of the dysfunctional way the state and private sectors frequently interact in Haiti, and my perceptions of how private, foreign NGOs are undermining the work of the state in providing social services. However, it is not only small NGOs like MFH that contribute to this imbalance. James Pfeiffer's article, "The Struggle for a Public Sector: PEPFAR in Mozambique" (2013) addresses the ongoing deliberation over public-, private-, and community-lead services. Pfeiffer describes a post-colonial African state in the throws of an epidemic subject to the full weight of the global interventions described above: PEPFAR (The President's Emergency Plan for AIDS Relief), the Global Fund for AIDS, Tuberculosis, and Malaria, and the structural adjustment programs implemented by global financial institutions in previous decades. Pfeiffer's analysis is key to understanding not only the differences in private and public approaches to medical practice, but the relevance of funding to those practices.

While international donors historically gave to national health ministries through "basket funding" (p. 169), PEPFAR, begun in 2002, relied on NGOs for service provision and limited its influence to HIV/AIDS projects alone. According to Pfieffer, this was a vertical approach that:

> avoided addressing either the larger needs of the health system or the broader social concerns of the hundreds of thousands of extremely poor patients targeted for treatment….This resulted in the creation of parallel medical supply, data collection, and management systems dedicated only to HIV(p. 169).

Even as resources for addressing health concerns of the public were greater than ever before, global actors still favored lean, vertical systems and constraining the spending of the Mozambique government, undermining an accessible and viable public health.

These practices are at work in Haiti as well, and Mullings, Werner, and Peake argue they result from racism and a racialized discourse of black criminality in "Fear and Loathing in Haiti: Race and Politics of Humanitarian Dispossession" (2010). Beginning by describing the delayed humanitarian response to the 2010 earthquake by international actors, the authors attribute the destabilization of the Haitian state and Haitian organizations to historical racism that "continued to locate the source of Haiti's crisis in its people, their inability to embrace modern liberal democratic ideals, and their propensity towards criminality and violence" (p. 288). An "almost pathological obsession with the issue of corruption" (p. 293) in Haiti means that what funding is provided to the Haitian government is subject to harsh conditionalities and mechanisms of control, and that remaining funding is funneled through NGOs and international government agencies who pursue objectives of their own.

A government working within these limitations is bound to fail at providing public services and face even more admonition from external actors. Support and collaboration with public systems is essential, but extremely difficult in a landscape dominated by U.S. actors acting out narratives of U.S. individualism and simultaneously criticizing the state for failing to meet expectations. Many of these external actors then engage with community-led endeavors and non-formal approaches to health, which I discuss further in my findings.

3.5 Applicability to the Research

This research begins with the framework of the Three Delays, but it cannot rely on this framework alone. In order to understand approaches to maternal health, I must also draw heavily from the extensive background research of Maternowska (2006) on the influence of international aid money as well as Haitian history and culture and politics on reproductive health practice in Haiti. Mullings, et. al,'s humanitarian dispossession will also guide my exploration of the pain and control mechanisms that are shaping the current landscape of Haitian healthcare. Themes of individual and institutional; global and local; technical and social; modern and traditional; and public, private and community will form the basis for my analysis of the maternal health sector. As relevant as the Three Delays are, the framework can not be applied in ways that are totally ahistorical or purely social, nor completely institutional or fully non-formal.

4. Research Design

My Capstone research is a loosely structured case study of the maternal health sector in Haiti. I began with the intent to explore different models and philosophies directing maternal health care in Haiti's low-resource environment. I was introduced to the framework of the Three Delays early on in my collection of data. I chose to use it to shape and better understand the data around the case. I also explored ways that the framework of the Three Delays was not sufficient to explain phenomena and activities taking place in the maternal healthcare sector in Haiti.

Creswell (2006) writes that "case study research is typically extensive, drawing on multiple sources of information, such as observations, interviews, documents, and audiovisual materials" (p. 75). An essential element of my research was the participant observation I conducted from within my practicum position as Program and Partnerships Director with MFH. As noted above, MFH is based in Richmond, Virginia with operations in Hinche, Haiti. MFH's model is made up of five central programs. The first and oldest is a one-year course to become a Skilled Birth Attendant (SBA). The course is available to certified Haitian nurses and auxiliary nurses, and qualifies them under government standards as nurses with advanced obstetric training. SBAs are distinct from Haitian Nurse Midwives or Infirmière Sage Femmes (ISFs) who are trained at a state medical school in Port-au-Prince. After their graduation, MFH seeks to place and support the SBAs in clinics and hospitals with need for skilled maternity care. To date, 18 SBA graduates staff the regional Hospital St. Thérèse, run by MSPP. Without them, the hospital would have only three ISFs and three OB doctors to manage between 200 and 300 births a month.

In addition, MFH runs a mobile clinic that travels to 22 sites in the Central Plateau that are at least 30 minutes away from hospital care. The mobile clinic is staffed by SBA graduates

who provide prenatal and postnatal care, as well as referrals and transfers to equipped medical centers. MFH also provides an outreach training program for *matwòns* to ensure they can identify danger signs and refer mothers to equipped medical centers. Finally, MFH has opened a birth center in an even more rural town called Cabestor that will be staffed by a government doctor and SBAs, and serve as a clinical practice site for students in the SBA class.

To date, I have been working in Hinche with MFH for 11 months. My work here has focused on strategic plan implementation, program coordination, data management, and most important to me, partnership development. Once these SBAs graduate from our program, they need to find employment within Haiti. In my work to find and place graduates with government, private, and NGO clinics and hospitals across Haiti, I have become familiar with a wide variety of models and philosophies of maternal health. Some organizations focus on outreach and mobile services, while others strive to improve and standardize centralized hospitals. Supplies, infrastructure, and human resources are extremely limited. In the midst of all of these approaches, the MSPP is setting standards and objectives of their own, and is reliant on the resources of others. While working with MFH has made me partial to the organization's broad, multifaceted approach to maternal healthcare, it is also because of the very nature of this approach that I have been exposed to such a wide view of the health sector in Haiti.

In addition to this participant observation, I also conducted my research in the following four forms: (1) In-depth interviews with four medical professionals who work or have worked in Haiti; (2) a voluntary, anonymous survey taken by adult SBA students who participate in MFH's SBA education program; (3) 14 site visits to medical facilities offering maternal healthcare services in Haiti; and (4) a review of existing literature on healthcare in low-resources settings and the Haitian context.

I did not work with any vulnerable populations or children to conduct this research. All participation from human subjects was voluntary and done with information regarding the objectives and uses of the research. The Haitian participants I engaged do no speak enough English for the interviews or survey to be conducted in English, so I conducted my interviews and surveys in Creole. I also involved a Creole translator throughout the process to support me in translation and ensure explanations and responses are provided with accuracy both verbally and in print.

4.1 Interviews

I interviewed three Haitian medical professionals and one U.S. American medical professional who have all been working in their fields for at least two years and have an understanding of the field's need for study. I specifically focused on respondents who had worked in many different settings across Haiti and would be able to provide a broad view of the maternal health sector. The in-depth interviews I conducted were anonymous in name but the study may still include identifying features, as the roles and employers of the interview participants are essential to shaping the context of their responses. Interview participants were informed this was the case. Their responses were kept confidential and destroyed following the research.

These four interviews conducted were with the following people:

- Subject 1: A Haitian Nurse Midwife (ISF) who has worked at NGO, private, and government health centers and hospitals in both urban and rural Haiti.
- Subject 2: A Haitian Nurse Midwife (ISF) who has worked in community health with both large and small NGOs in leadership roles.

- Subject 3: MSPP's Head of Family and Reproductive Health for Center Department and Nurse Midwife (ISF).
- Subject 4: A U.S. Certified Professional Midwife (CPM) who has volunteered in four different maternal health settings in Haiti, as well in the Philippines, Ghana, and Cambodia, and Vietnam.

4.2 Survey

I developed a brief survey to give to the 30 students currently enrolled in MFH's training program. Since participants would likely have been biased toward the benefits of Midwives for Haiti's model, the survey primarily collected information on what maternal health services are available in their home regions across Haiti. Since the students come from nine out of Haiti's ten regional departments, the survey was intended to give me a basic sense of the scope of services available throughout Haiti as a starting point for my case study.

In contrast, the students who participated in the survey were kept anonymous and referred to by numbers rather than names. The content of their responses was kept confidential and destroyed at the conclusion of the research. While the SBA students do benefit from MFH programs on a daily basis, their participation was totally voluntary and did not have any bearing or relation to their studies within the MFH organization. The survey was designed to elicit responses about their professional careers in Haiti and the health sector *before* they came to MFH, so they did not feel pressured to give responses that satisfy what they think MFH might have wanted to hear about its program. The survey took place after class hours so that those who did not want to participate were not pressured to do so by required presence in the classroom. Survey and interview participants all signed informed consent forms.

4.3 Site Visits

I conducted site visits to different medical centers and clinical settings across Haiti as both as part of my research and as part of my role as MFH Program and Partnerships Director. These included MSPP hospitals, clinics, and dispensaries, NGO hospitals and maternity centers. Through these visits I had a chance to see different models of maternal health in action and gain a basic sense of what care is available to women in Haiti and in what regions.

The questions I explored on each of these site visits are included in the appendices. The institutions I visited will not remain anonymous, but I did not mention the names or any identifiable information about anyone who I encountered or spoke to on these visits, as they did not have the opportunity to provide consent.

Site visits took place at the following locations:

- **Hospital St. Thérèse (HSTH) – Hinche**

  HST was founded in 1925 during the U.S. Occupation of Haiti. It is the referral hospital for the Centre Department, a catchment area of around 200,000 people. It sees between 200 and 300 births a month, and receives funding from MFH, Zanmi Lasante, Rotary International, and Ohio State University.

- **Midwives for Haiti Mobile Clinics (MFH MC) – Central Plateau**

  The MFH Mobile Clinic started operations in 2011 and visits 22 sites across the Central Plateau four days a week, four weeks a month. It is staffed by six SBAs and provides comprehensive prenatal and postnatal care and offers referrals and transports to other clinics or hospitals. Found travel by car to sites of between 30 to 130 patients, while two travel by motorcycle to sites of 10 to 20 patients.

- **Midwives for Haiti Carrie Wortham Birth Center (CWBC) – Cabestor**

  The CWBC was opened by MFH in November of 2015. The center replaced a long-running site for the MFH Mobile Clinic. It is staffed by two SBAs and one nurse assistant and is located around 45 minutes away from the city of Lascohobas on a dirt road.

- **Hospital Albert Schweitzer (HAS) – Deschapelles**

  HAS was founded in 1956 by the U.S. American Larry Mellon and serves around 350,000 people through both its hospital campus and community satellite projects. They have a maternity wing focused on high-risk maternity care.

- **Hospital University Mirebalais (HUM) – Mirebalais**

  HUM was opened in early 2014 as part of Partners in Health/Zanmi Lasante operations in Haiti. It is run in partnership with MSPP and sees around 700 patients a day. The hospital serves as a site for medical residents to learn and focuses on high-risk maternity care.

- **Hospital St. Croix (HSC) - Leogane**

  HSC is a 120 bed hospital founded in 1973 with support from the U.S. Presbyterian Church. MSPP designated the hospital as the official health authority for the Leogâne commune and a government building near by is used for their maternal and child health program. HSC sees an average of 57 births a month.

- **St. Croix Birth Center - Darbonne**

  The birth center Darbonne was started in 1984 as a part of HSC's community outreach. It is located about 15 minutes drive away from Leogane, employs one SBA and seven support nurses. They see between 50 to 80 births per month.

- **Family Health Ministries Birth Center (FHM) – Fondwa**

  The Carmelle Voltaire birth center opened for in February and has not yet started offering maternity services. FHM has operated in Haiti since 1993.

- **Women and Children's Hope Foundation (WCHF) - Fondwa**

  Hope Foundation does community building, agronomy, and women's empowerment activities, including family planning education and matwòn training. It is located completely off the road: 30 minutes walk down the side of a mountain.

- **MSPP SONUB – Marigot**

  The SONUB in Marigot receives support from UNFPA for a specific maternity program developing "Smile Clinics". There are four Smile Clinics around the country, opened in 2012. The Marigot clinic sees between 30 to 40 births and around 200 women for prenatal care per month, and employs two ISFs.

- **Maison de Naissance (MDN) – Torbeck**

  MDN is a birth center supported by the Global Birthing Home Foundation. The clinic opened in 2004, but in 2014 stopped offering births due to financial constraints. It currently employs one ISF, three SBAs, two nurses, and seven auxilliares. When the center did offer births, it did around 100 per month.

- **Friends of Health in Haiti (FOHH) – Gatineau**

  The FOHH clinic started in 2014 in the mountains outside Jeremie and sees about 30 to 40 patients a day. They have only just begun to explore offering maternal healthcare, but have strong community heath roots.

- **Mama Baby Haiti Maternity Center (MBH) – Cap Haitien**

MBH is a birth Center on the edge of one of Haiti's northern cities and provides free prenatal, birth, postnatal care and other reproductive health services. It employs five SBAs who live on site.

- **Heartline Ministries (HM) – Port-au-Prince**

  HM is a birth center in Port-au-Prince staffed by three CPMs from the U.S. and several Haitian nurses. HM aims to manage 10 low-risk births a month, and so interviews and selects women who will be invited into their practice and require to take prenatal and postnatal classes.

Additional visits were made to maternal health centers including St. Damien Hosptial (Port-au-Prince), Olive Tree Projects (Jacmel), Whitney Clinic (Hinche), Medishare Materntiy Center (Marmont), Partners in Development (Port-au-Prince), Visitation Clinic (Petite Riviere de Nippes), MSPP Hospitalier Lascahobas (Lascahobas), MSPP Cerca Carvajal (Cerca Carvajal), St. Famille Clinic (Cerca Carvajal), and St Joseph's Clinic (Thomassique). However, I did not collect sufficient information about maternal care at these sites to effectively analyze them in this study.

4.4 Relationship with Midwives for Haiti

One of the objectives of this capstone research is that MFH, as well as the maternal health field could benefit from this study and gain further understanding of the context in which they work. I conducted and compiled this research on my own time, and clarified to all interview and survey participants that my role during this study was as a Master's student, not a MFH employee. MFH did not have access to any of my results during the research process. However, MFH will be able to read and benefit from my research when my capstone is completed.

4.5 Limitations

The primary and largest limitation was language. While I am highly fluent in Creole, there were still times when I was unable to understand an interviewee's response to my question at the moment it was given. Translators were present during my interviews but generally did not translate word for word. All interviews were audio recorded and I listed to audio tape afterward to understand what had been said and then translate into English for transcription purposes. This mean that I was not always able to ask follow up questions of respondents during points in the interview when I might have wanted more information. In contrast, my sole interview in English with Subject 4 was longer and more relaxed. Interviews with Subjects 2 and 3 also took place in their places of work where there were some distractions and I was wary of prolonging the interviews and disrupting them from their work for too long a period.

The makeup of the study participants also carried some limitations. Because of the nature of MFH work, I am primarily exposed to the work of midwives. All subjects interviewed were midwives or nurse midwives, and the students who participated in the survey were all studying to become SBAs. As a result, responses and findings overwhelming represented one particular profession. OBGYNs, women's health nurses, matwòns, or community health workers, all who would have important insights to the women's health sector in Haiti were not interviewed. However, alternative understandings of women's health were observed and obtained through my numerous site visits to clinics, hospitals, and birth centers across Haiti.

4.6 Subjectivity

My own biases as a highly educated, white woman from the U.S. who grew up both in the U.S. and Tanzania also factored into the scope, direction, and analysis of my research. I had

worked and lived in Haiti and other regions in the Global South as part of international development projects, though I had not been exposed to midwifery or maternal health before working at MFH. This meant my analysis was often shaped by understandings of global development projects and objectives. Because of my international experience and background, I felt more comfortable using a comparative lens and viewing and understand the sector from a certain distance. My relative privilege as a white U.S. woman in Haiti also meant I was allowed access to many sites with little trouble and perceived as someone researching with good intentions.

5. Findings and Analysis

All data elicited by the interviews, surveys, and site visits aligned well with the framework of the Three Delays. Subject 1 even spoke of them directly, referring to three delays that could lead to a maternal mortality, and implying that there was need for investment in community awareness, transportation, and hospital procedure as one continuous system. Most importantly, the research illustrated that public, private, and community level approaches to maternal health were not focused on one delay alone, but worked in varying degrees to combat all three, even as the delays themselves remained distinct challenges. However, they also described a much wider array of forces contributing to maternal health in Haiti, and described the multi-faceted way various stakeholders in the field are constrained by both local and global factors in their ability to define and implement priorities around maternal mortality.

As elaborated in my literature review, many earlier researchers argued that the technical medical capacity of institutions to manage obstetric care should be prioritized, as it is this capacity that contributes to the 1st and 2nd delay. It is for this reason I begin by considering the 3rd delay, and two efforts working at the institutional level, to combat it: the state referral system, and an initiative called *Soins Obstetricaux Gratuits*. I then discuss the 2nd Delay, and how it relates to approaches to improve the distribution of health services. Finally, I address the 1st Delay, and how it is exacerbated by practices of resistance, Post-Colonial medicine, and the politics surrounding institutional births.

5.1 Delay #3

The Third Delay is the delay in receiving adequate and appropriate treatment at a health care facility. In order the illustrate the degree to which this delay is engaged in the studied

approaches, I will use the building of capacity in formal institutions like hospitals or high-level clinics as a proxy. My research identified two approaches to institutional capacity building and the elimination of the third delay: the first was a defined referral system, wherein different facilities had uniquely defined scopes of practice and referred patients to each other when a case fell outside that scope. The second was an international funded program called *Soins Obstetriques Gratuites* (SOG) or Free Obstetric Care, which, while in place, had substantially subsidized the cost of obstetric care at MSPP health facilities. However, it was also clear from my findings that these programs and priorities were often shifting.

5.1.1 Referral System

A common cause behind the 3rd Delay is that women are able to reach *a* health care facility, but are unable to reach the one that could handle their obstetric complication. Barnes-Josiah, et. al,'s case studies depict several women who, after receiving care at one institution, were not referred appropriately or could not reach the referral institution. Part of building institutional capacity at the public health level is building a strong set of referral protocols that outline what level of care is available where. Subject 1 and Subject 3 both extensively discussed the system of referrals not only between matwòns and health centers but also from one institution to another. In MSPP's vernacular, these institutions are called SONUs: *Soins Obstétricaux et Néonatals Urgents* or Urgent Obstetric and Neonatal Care. They are then distinguished by the letter B for *base*, or basic, or C for *complete*, depending on what level of care they could manage.

However, the evidence demonstrated that these referral protocols were not always upheld perfectly. Subject 1 attributed many maternal deaths to these failures of the referral system:

"[She] needed a C-section, so she died from a postpartum hemorrhage. But that person

> shouldn't have gone to the SONUB, they should have gone to the SONUC. So then they write, this was a maternal death, she died of a hemorrhage. But they don't look for the cause of the hemorrhage, to realize she wasn't supposed to stay in the SONUB, with that problem she should have gone to the SONUC."

In this response, the capacities of SONU centers are well defined and the need to follow protocols for transfer is emphasized. Subject 1 also implies that the answer to the obstetric complication is a C-Section that is not always available. Her example bears a close resemblance to the story of Mrs. X. A woman arrives at a small hospital too late, and the small hospital does not have sufficient capacity to address her complication.

The MSPP Center of Marigot was the clearest example of the referral system in practice. Marigot is a small town in the South East with a population of around 69,000 people (Sérant, UNFPA, 2012). The center had been revamped by UNFPA in 2012 to become a *Clinique Sourire* or a Smile Clinic, and had two ISFs practicing with seven nurses to support their work. The financial support of UNFPA had turned the center from a clinic with a few tables on which to give birth to a full-service maternity center. The center was clearly delineated as a SONUB center by a sign out front, and referrals for obstetric emergencies, particularly those that need C-Sections, were transferred to St. Michel Hospital in Jacmel, 30 minutes' drive away. These referrals decreased stress on the SONUB and allowed the center and its human resources to be available for less complicated births and other primary maternal healthcare.

UNFPA's support had clearly been directed to building institutional capacity at a secondary facility that could then refer complications to the nearby hospital without hurting for resources. I found that this served as a model of the ways powerful global actors like UNFPA could collaborate and bolster the localized public health system, but it was not clear from my site

visit the degree to which these institutional approaches were fulfilling the needs of women in the community, especially those reluctant to visit formal, government institutions.

5.1.2 Soins Obstetriques Gratuits (SOG)

SOG was pioneered by the Pan-American Health Organization (PAHO), the Canadian International Development Agency (CIDA) and WHO. The program significantly subsidized the cost of maternity services at MSPP health centers from 2008 to late 2009. Initially, 50 centers were chosen based on the quality of their services and required to report on their quantity and quality of patient care. Subject 3 highlighted SOG as a successful approach. The program not only supported institutional capacity but also the addressed the other two delays: transportation and the willingness of communities to refer women. A WHO publication describing the program states:

> Key elements of the project include: payment to health facilities for pregnancy, birth and postpartum services; refunds to pregnant women for transport costs; and payment to traditional birth attendants who accompany pregnant women to the health institutions for birth. Facilities are only reimbursed if they send for approval a standardized record of the care given to each woman (WHO, 2010, p. 3).

Following the 2010 earthquake, the program was merged into a broad maternal and child health project funded by UNFPA and UNICEF, called *Maman ak Timoun nan Sante* or Mother and Child Health. This initiative focuses on building institutional capacity and only provides free prenatal care and health services to children under five. (PAHO, 2011). Free births and C-section care are no longer subsidized.

Financial support from ZL allows Hospital St. Thérèse to provide free birth care for birth natural birth and C-sections. A small fee is still charged for a bed and patient form and patients

are often required to purchase their own supplies when the hospital is short. Other centers without the support of Zanmi Lasante, like Hospital St. Croix in Leogâne, does not receive these subsidies is currently charging 2500HTG (roughly $40) for natural births and a prohibitive fee of $400 for C-Sections.

The loss of funds for matwòn referrals was also significant. In the early 2000s, MSPP designed a curriculum that trained matwòns to do clean deliveries and recognized when women with complications needed to be transferred to the hospital. However, in the last few years, MSPP has discontinued support for this curriculum entirely. Subject 3 suggested that MSPP believed motivating matwòns to bring women into the institution would accomplish little if the institutions themselves were ill-equipped to handle EmOC. In this, they echo Barnes-Josiah, et. al, who state that "the benefits of obstetric care must be real" (1994, p. 991).

However, Subject 3 spoke of the problems that arose contradiction when matwòns who were used to receiving reimbursement were suddenly asked to go without:

> When they know that they are coming from far, even when they come with the woman to the hospital, [the matwòn] comes with two hands, two feet, and doesn't receive anything, that doesn't encourage them to bring them. So when [the matwòns] keep women at their homes, do the births, they know when the woman has something [wrong], even so, they do it.

The loss of this support, Subject 3 suggests, has predictable negative consequences. Women with complications are still delivering at home as a result of their matwòn's relationship with the health system. Subject 3 had worked for many years in community programs with matwòns and community health workers, but has now become part of MSPP's shift to focusing on institutional improvement and capacity building. Her response conveys that there is something lost in the

state's turning away from matwòns: "we are still informing them, but they are alone."

While MFH and other NGOs in my area believed MSPP chose to cease support of matwòns for unfounded reasons, the decision to focus instead on institutions likely came not only as a result of MSPP authorities, but of the funding choices at global levels. Nevertheless, the rise and fall of this successful intervention is a clear example of how short-term global funding strategies have long-term implications, especially for the health practices happening outside formal institutions, which are often the first to be left out of public approaches.

5.2 Delay #2

Overall, few projects and subjects directly addressed the 2nd delay, failure to reach a medical facility in time. Thaddeus and Maine note that while Phase II delays are frequent, they receive little attention in the literature (p. 1100, 1994). No sites I visited had a specific program designed to address the challenges of traveling from one place to another, such as improving road conditions or public transportation options. One center, FOHH, distributed ten stretchers to ten different communities in their catchment area that could be used communally if someone sick had to be brought to their clinic. In the absence of other transport focuses projects, it is useful to examine the distribution of medical facilities across Haiti and the degree to which they are improving physical access to new populations. Thaddeus and Maine state that to address the physical distance to care, "either pregnant women have to move closer to the services, or the services have to move closer to the women" (p. 1106).

5.2.1 Distribution of Services

Many clinics addressed the 2nd delay by choosing to place themselves or distribute their services in geographically remote areas, reducing the distance those patients would have to travel and addressing the grave imbalance between urban and rural access to healthcare. FOHH, MFH, and WCHF had all decided to locate their services over 45 minutes outside urban areas, with the intention of serving as-yet unserved populations on roads that were impassable or difficult to

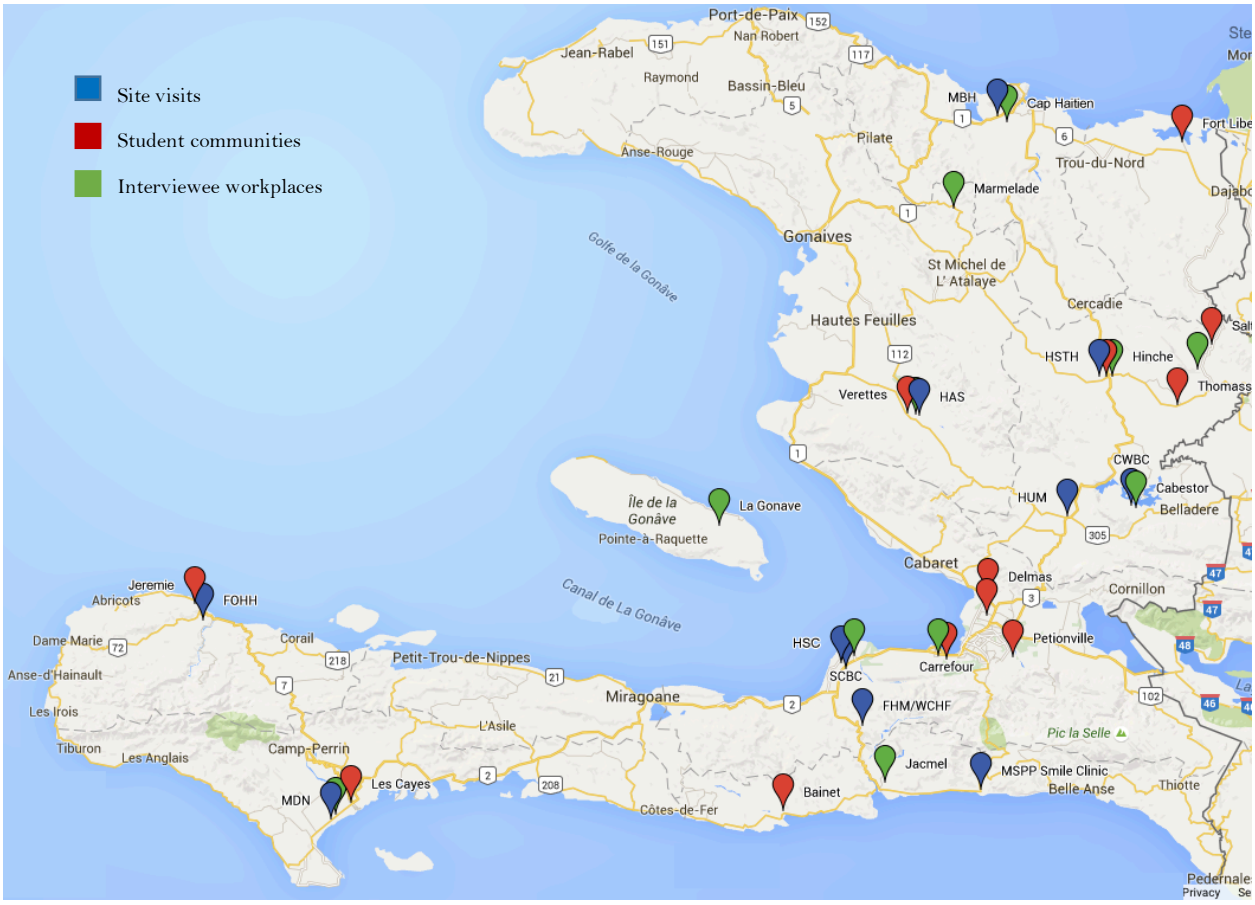

Figure 2: Map of sites and relevant locations in Haiti

manage with vehicles. In contrast, the SCBC, MBH, FHM, HAS and MDN are in small towns on the edges of large urban areas like Leogâne, Cap Haïtien, and Les Cayes, usually have paved roads nearby, and can be reached with public transport or motorcycle taxis in less than 20 minutes.

HUM is located directly in the city of Mirebalais, but is still able to serve an underserved population as the highest-capacity hospital in the Centre Department.

Programs like MDN and HAS also further define their objectives by focusing on a particular geographical area. MDN conducts targeted outreach for the Torbeck neighborhood alone. HAS offers substantially lower prices for persons within their surrounding 610 square mile district, though it is unclear if this geographical distinction falls under any government-defined administrative level. HM in Port-au-Prince, limits their patient population by interviewing and selecting women to take several months of prenatal courses before agreeing they can give birth at the facility.

MSPP hospitals are located in urban areas, like Hinche, Cap Haïtien, Jacmel, and Port-au-Prince. However, there was an imbalance in the numbers of hospitals in each of these regions. MSPP clinics were typically also placed in remote locations, usually in the midst of a small town or regional hub, like Cerca Carvajal or Maissade (both in the Centre Department) that had local administrative powers at the commune level. MSPP also populated less trafficked areas with small dispensaries.

The student survey also produced important information about the distribution of medical services, at least from the perspective of health care workers. As noted above, the students who took the survey came from nine out of Haiti's ten departments: Artibonite, Centre, Grande-Anse, Nippes, North, North-East, North-West, South, South-East and West. Students typically came from the urban hubs in each of those departments, though not exclusively. When asked what health services were available in their area, those from Jéremie (Grande-Anse), Les Cayes (South), Hinche (Centre), and Verrettes (Artibonite) reported that MSPP Hospitals were nearby, reflecting wide, but not thorough, coverage. Those from Port-au-Prince also mentioned

MSPP Hospitals, but only in some sections. Residents in the Port-au-Prince suburbs of Carrefour and Petionville had to rely on private hospitals, private clinics and NGO hospitals. In addition to these two West Department suburbs, three other areas had no MSPP presence whatsoever: Saltadère (Centre), Thomassique (Centre), and Fort Liberté (North-East).

NGO services were available in different regions, but were still not complete. NGO hospitals, clinics, and services were reported in Bainet (South-East), Jéremie (Grande-Anse), Hinche (Centre), Port-au-Prince (West), particularly Carrefour and Delmas, Les Cayes (South), and Thomassique (Centre). MSPP reports 122 hospitals for a population of 10 million, including both private and public. 70 of these are in and around Port-au-Prince. In addition, there are 926 health centers and dispensaries, but once again, most of these are located in the Port-au-Prince area or the Artibonite Department. 8% of MSPP institutions were listed as non-functioning in 2015 (MSPP & UEP, 2015, p. 5-6). Saltadère, Fort Liberté, and Petionville reported only private hospitals, clinics and pharmacies, though the student from Saltadère reported a mobile clinic (most likely that of MFH).

In the absence of public, MSPP services, private and community services proliferate, and further contribute to the belief on the part of external actors that the Haitian state is not taking responsibility for the health of its citizens. Global standards of institutional health put pressure on MSPP to provide advanced care, meaning that small, community-level NGO actors filled the gap of primary healthcare. Subject 4 argued that MSPP was not favoring initiatives like task shifting certain maternal care practices to midwives that would bring primary maternity healthcare options to more people in a systematic way, but rather attempting to adhere to a doctor-heavy U.S. model of care:

But what they do is they say no we're not going to do it until we can have a doctor. And

> so as long as they say, you have to have a doctor, it has to be the U.S. model, I mean, I blame the United States for telling them it has to be a U.S. model. Because as long as they're trying to do the U.S. model, I think it will be almost impossible. And I think if they look at what other low-income countries are doing they can make it happen pretty quickly…. You have to trust midwives… you certainly have to trust the ones that you can get out there as quick as you can. You have to believe what they're doing is better than nothing. And then you can raise the standards once you get the healthcare out there.

Subject 4's argument has a few layers: that the Haitian government is setting impossibly high standards for their rural maternal services; that they are emulating a U.S. model; and instead, they should be prioritizing midwives and other human resources who could more easily have the sufficient numbers to be out in the rural areas now. Her response implies that the Haitian government could be taking more action to improve the distribution of services and reduce the 2nd delay, but is choosing not to do so in favor of adhering to a global push towards institutionalization.

Subject 4's experiences on the island of La Gonave also seemed to suggest a choice on the part of the government to not bring care to where it was most needed. She said there was no presence of MSPP on the island whatsoever, and that even in their absence, international actors and NGOs failed to coordinate effectively. She discovered while working with a maternal health clinic there that it would only take a vehicle visiting 14 sites through a mobile clinic program to ensure that no woman on the island had to walk more than one hour to receive prenatal care, a WHO standard. Yet there were too many organizations, largely driven by different religious groups and churches that did not appear to be working together.

The community and private initiatives operating in settings like La Gonave no doubt

believed they were filling a local necessary need. However, it was not uncommon in my research to discover that MSPP institutions were in fact present in undeserved areas, but were unused, neglected, or confined to narrow ranges of operation. In the meantime, NGO and private projects, often short-term medical mission teams, conducted less formal community outreach, typically connected with more patients, and felt more comfortable focusing on individual care rather than institutional capacity building. These smaller projects rarely connected with each other or MSPP, nor did MSPP connect with them. Thus stakeholders involved in these approaches had a deficient understanding of the full extent of the maternal health sector.

5.3 Delay #1

Thaddeus and Maine argue that both the 2nd and 3rd Delay contribute to the 1st: the delay in the decision to seek care on the part of the individual, family or both. Supposing a clinic is available and within walking distance for a woman, she may still not want to travel there for her care if she is not experiencing an obstetric emergency, or even if she is. Gage and Calixte reference an earlier study done in Guatemala that reported:

> The availability of private physicians and government-sponsored health services within communities had only a modest effect, relative to the effects of socio-economic factors, on rural women's decisions to obtain care during pregnancy, which supports the argument that the expansion of public health facilities may not be enough to promote equity in service utilization in rural areas if people are not willing or able to avail themselves of the health services offered. (2004, p. 272)

There are numerous reasons why women may not want to seek care at a health facility. These can result from cultural and religious beliefs about the necessity of biomedicine, the knowledge that a

clinic is too far to reach, or because previous experience in that institution was negative or ineffective. Resistance to formal institutions, as well as the often violent practice of post-colonial medicine and the acceptance or lack thereof of the value of an institutional birth are particularly relevant for understanding the 1st Delay in Haiti, so these are discussed below.

5.3.1 Resistance to Formal Institutions

Resistance to formal institutions is particularly apparent when examining the MFH mobile prenatal clinic. The mobile clinic travels to 22 sites each month in the Central Plateau, going out 4 days per week, 4 weeks per month to a different remote community each day. The car mobile clinic is staffed by four SBAs, though two others go out on motorcycles or join the others for particularly busy sites. Until the opening of the CWBC in November 2015, this clinic was the only instance in the MFH program where employees were providing a direct medical service to women under the leadership of MFH. The SBAs typically set up in a community space or church, though sometimes they operate outside or in the private home of a community member. The clinic is an expensive program, and in many ways an unsustainable one. Yet it is extremely popular with rural woman, and sees between 600 and 800 women each month.

MFH initially intended to build up sufficient SBA graduates and partnerships to place a permanent midwife in each site the mobile clinic visited and replaces its services, enabling a permanent and sustainable source of care for women, and improving the distribution of services. One of the first places where this happened was in the town of Dos Palais, a site within one hour of Hinche, where the mobile clinic had worked in the vicinity of a clinic run by a Catholic church. MFH was able develop a full-time position for a graduate at the clinic and shifted the mobile clinic's services elsewhere.

Despite this ostensibly sustainable and positive change, an MFH employee told me the

following story: On the last day of the Dos Palais mobile clinic, the mobile clinic SBAs handed over their box of patient files to the new, stationary SBA, and got ready to leave. Outside the Catholic clinic, they encountered a final pregnant woman, waiting to see them. They said the mobile clinic had ended its services and that she could go inside the clinic and find her patient file and another SBA to handle her care. The woman was angry and disappointed and chose instead to leave the site without seeking care at the facility that was in front of her.

A story like this is important and necessary to understand that the proliferation of public, private, or NGO clinics may not be sufficient to address the Three Delays. Subject 4 posited in her interview that, in fact, Haitian history may have motivated rural women to not seek care, or to remove themselves from the populated areas where they might access it. This, she said, was evidenced by the courtyard or *lakou* style of Haitian living where the houses of several family members were clustered together and dependent upon each other, socially and economically.

> The *lakou* is a revolutionary…system of social organization that everybody talks about because they *lakou*s were separated by tiny trails not roads. And what I read was that that was intentional. So even though they knew that roads would be useful for some things, their goal was self-sufficiency and privacy from the government. And they actually didn't want people to easily be able to get back up there. So now we're having a hard time getting women out to have their birth, but those little trails aren't just because they were poor and didn't know to make roads, they didn't want the roads.

Haitian history, as Subject 4 suggests, is essential to understanding the current motivations and disadvantages women rural face when choosing to seek or not to seek medical care during their pregnancy and birth. This history plays out in many of the sites in this study. While the construction of Hospital St. Thérèse in Hinche can be seen as a positive result of an otherwise

violent U.S. occupation, its history may also signify to Haitian women that to visit the hospital is to lose their autonomy to an unfriendly Haitian state. Centuries of oppression through slavery, colonial occupation, violent dictatorship, and militarism have resulted in a survival strategy of distance and inaccessibility for rural populations.

5.3.2 Post-Colonial Medicine

The historical pain discussed above is compounded by very real practices of shame and what Maternowska (2006) and Babalola (2014) call "social distancing" in the clinic setting. Maternowska writes of the family planning clinic that she studied:

> Social distancing in this clinic, reinforced by social space, ensured that clients felt like outsiders, even though the clinic was, ostensibly, there to serve them. As the staff gained professional status, they were located farther and farther from the waiting room, where clients convened (p. 81).

Across Haiti, imbalanced relationships put doctors, nurses, and midwives in positions of authority and holders of class and educational privilege in communities where access to this form of advancement is almost non-existent.

Subject 4 found these tensions particularly difficult to face during her time with the clinic on La Gonave. She believed that the clinic failed to draw any patients because of the animosity it had demonstrated towards community members in the past.

> I just started walking from village to village and I went to the market and set up a little booth. Like, telling people that there was prenatal care…but I think that [the clinic staff] had been historically mean to the poorest people and so people were scared of the clinic. And because there was right there outside of the clinic really sick people, like dying people and they would not go in that clinic for anything. They would rather die than go in

that clinic.

This, along with the previous commentary by Subject 4 about the *lakou*, suggest a complicated set of reasons for delaying the decision to seek care.

Even when doctors and nurses are not deliberately enacting emotional pain and social distancing on patients, my year of working with MFH and the Hospital St. Thérèse provided many glaring examples of medicine that hurts patients, even as it heals them. One MFH volunteer witnessed a C-section performed without anesthesia, while another observed a pregnant, HIV+ teenager refused a bed for several days. Another saw an OBGYN make jokes about the body of a stillborn baby. In *Improvising Medicine*, Livingston (2012) spends ample time unpacking the racialized practices around pain and patient treatment that sustained colonialism and slavery and persist even after their conclusion.

Most commonly, patients in hospitals across Haiti are required to pay for medicines and equipment before they receive care, but this is not considered unusual. In a hypothetical story about inadequate EmOC, Subject 1 suggests that a competent medical professional should continue to administer care while the patient's parent is out purchasing equipment. She does not suggest this purchase should be unnecessary, reflecting an acceptance that care and medicine is costly, and that both the hospital and patients are responsible for bearing these expenses.

However, these medical practices and unforgiving calculations should not be understood as uniquely Haitian phenomena, but rather ones that arise in the midst of severe resource limitations. Subjects 1, 2 and 3 all attended the same nursing and midwifery programs in Port-au-Prince, and both Subjects 1 and 3 remarked upon the high levels of stress they experienced during their years there. Subject 1 describes the period:

It was a competition, a lot of stress, and on top of that the situation of the country, you

> know the country has a lot of stress in the streets, lots of stress in the school, eh, and where you do clinical rotations is in the General Hospital, where there a lot of cases, where people don't have a lot of materials and it's stressful.

Here, the stress of competing against fellow students and the stress of clinical rotations in an under-resourced hospital are conflated with stress in the streets of Port-au-Prince, suggesting that the life of a nurse-midwifery student is affected by Haiti's political economy. Their student lives are played out in Haiti's intense capital city, one that has borne the brunt of coups d'etat, police brutality, gang violence, and an earthquake in the 16 years since the school for midwifery opened. While nursing school is imagined in the Global North as a time for controlled learning that will be unavailable in later professional practice, the pressure and stresses of attending school in Port-au-Prince create a workforce deeply aware of resource limitations and the risks of academic failure.

Jewkes, Abrahams, and Mvo (1998) expand considerably on the values imbued by a colonial medical education in their study "Why do nurses abuse patients? Reflections from South African Obstetric Services." The authors write that when black women were first allowed to be trained as nurses in late 19th century Apartheid South Africa, historically "Nurse training was regarded as a socialization process, initiating students into a very particular ethos and entire way of life" and quote Shula Marks' (1994) argument that this socialization "served to distance African nurses from their communities and create a new middle-class elite"(as quoted by Jewkes, et. al, p. 1783).

As the evidence above shows, the Haitian university system today prepares students to graduate well-aware of the limitations and stress of medical care. The pressure and competition also social nurses, midwives, and doctors to understand their place in Haiti's small middle class,

and the stakes of not embodying it through social distancing in clinical practices. In order to truly collaborate with the public health system, and effectively reach out to communities and individuals across Haiti, it is essential to see how these public systems are also reenacting historical pain and creating social distances that prevent the maternal health sector from effectively serving all.

5.3.3 The Politics of an Institutional Birth

The Three Delays framework grew out of trying to understand the reasons women die in childbirth in low-resource environments, and in many cases the work to decrease maternal mortality is understood to be bringing higher numbers of women to an institutional birth. Yet underlying the conversation surrounding the 1st delay is a growing skepticism of the need for an institutional birth. This skepticism is particularly prevalent in modern U.S. midwifery practice, which arose in part as a response to the alienation women sometimes experience when giving birth in an institutional setting. Even as women's health advocates understand that institutional births are necessary in many cases to save lives, those promoting the U.S. natural birth movement still balk at the realities in those institutions, like the C-Section administered without anesthesia described above.

Historically, midwives were understood as traditional birth attendants who helped women give birth at home. In 1900, 95% of U.S. women did birth at home (Feldhusen, 2000). In 1921, the Sheppard-Towner Act provided federal funding for states to improve maternal mortality.

> In the years preceding it, officials and doctors blamed midwives for high rates of infant mortality, deeming them unhygienic and uneducated. The act forced midwives to become licensed and receive training from nurses. As medical professionals established

> relationships in communities that midwives once served, the use of midwives diminished in much of the country (Aghajanian, 2015).

By 1950, 88% of U.S. births occurred in hospitals, and U.S. midwifery has remained a strictly regulated and relatively rare health profession.

In response to these developments, Fannin (2006) writes that "Midwives in North America emerged in the 1960s as practitioners of a self-styled 'low-tech, high-touch' approach to pregnancy and childbirth, often actively resisting the increasing use of new medical technologies during pregnancy and birth" (p. 73). Nurse-midwives and professional midwives set up birth centers across the U.S. that were designed to provide a safe, homelike environment for women to deliver (Stone, 2000). Since then, U.S. midwifery practice has focused on the "intensely local politics of choice regarding pregnancy and birth and with provincial and state health care policies regarding professional rights to practice" (Fannin, 2006, p. 71). The maternal health sector in Haiti, particularly the midwifery profession, is also working through similar growing pains (see Magloire Civil, 2014 May 15).

However, in rural areas, 77% of Haitian women are already giving birth in the home with matwòns (MSPP, IHE, & ICF, 2013), so Haiti's medical and birth communities find themselves arriving at this dichotomy from a different set of circumstances. Subject 3 felt that "if we have the majority of women, 70% who stay to give birth at home, they can never arrive at their goal to reduce the maternal mortality rate." Subject 2 also believed in "a good birth in the center", but went further to say that bringing women to the hospital had to happen with contextual knowledge of community issues:

> Now they are making efforts to bring people to birth at the hospital for a better health condition, for a better condition of care, but don't forget that pregnant women are part of

> the community, so all of the taboos, all of the challenges at the community level, if we don't lift those challenges from the community level, it's the same issue.

The concept of community outreach was also used by the Haitian respondents as the point from which to augment institutional births. Subject 1 felt that the most successful approaches in Haitian women's health were those in the community, with the impact of that work measured in numbers:

> Go in to the community with a mobile clinic or meetings with matwòns… It's then you come to see that with it, if you have done twenty births in the hospital, the fact that you go into the community, you moved there and have a stronger presence in the community and when a concern arises, number of births will go up to forty, will go up to sixty.

Where midwives and birth workers in the U.S. seek to disassociate birth with sickness and hospitalization, midwives and maternal health professionals see motivating women to interact with institutional care as one of their main priorities.

MFH volunteers, often U.S. certified midwives, are generally proponents of a model of care that promotes a women-centered approach and fewer interventions. Many come to Haiti seeking to escape the hospital-centered context in which they work in the U.S., and express a desire to see home births in the Haitian context. Many are shocked when they visit Hospital St. Thérèse and find what they feel is a harsh, doctor-centered model of care. These supporters of MFH typically express nostalgia for Haitian birth they believe is "traditional". Yet as Fannin writes, this classification of which midwives are modern and which are traditional "[extends] along national lines of difference from First World (Denmark, the Netherlands, Spain, and the United States) to Second World (Russia) to Third World (Haiti)" and plainly delineate who is

"the bearer of traditional knowledge and who [holds] modern, scientific knowledge" (2006, p. 82). Those invested in maternal health and mortality must understand that the conversation around the definition of a good birth is still playing out at local and international levels.

6. Discussion: Shadow Delays

The findings and analysis above demonstrate that while the framework of the Three Delays is extremely helpful in understanding the foundations and practice of maternal health in Haiti, it does not fully describe the myriad dynamics taking place between MSPP, NGOs, healthcare practitioners, matwòns, and pregnant women themselves. Mrs. X, as the film identifies, did not only die of a hemorrhage, she died of social injustice. Yet in response to her death, the hospital staff are able to make protocol changes quickly without arduous discussion of professional hierarchies or public health funding. The WHO film attempts to examine the social determinants of health that lead to Mrs. X's death, but does not put Mrs. X's environment in context to understand the reasons why one maternal health system may crumble while another receives funding and attention. Beyond the three practical delays that a woman faces when trying to access EmOC are other shadow delays that prevent systems which could help her from speeding up.

6.1 Lack of Action, Lack of Autonomy

Overwhelming, the evidence shows that the Haitian public health system neither takes responsibility for health, nor is able to fully define their own priorities. Financial involvement and control from international donors directs and influences myriad policies and healthcare decisions in Haiti, even when those decisions are thought to be made by MSPP. Subject 1 said that "the very budget that the state has is given by internationals." In 2010, official development assistance (ODA) disbursed was nearly $3 billion. However, while most of MSPP's money may be coming from ODA, not all ODA is disbursed through the state. While total expenditure per capita from that ODA was around $46, only $9.95 of this was from general government spending

(WHO, 2012b). It is widely said that of the billions of aid disbursed after the 2010 earthquake, less than 1% was disbursed through the Haitian state or Haitian organizations.

However, in the midst of this imbalance, there was still a tendency on the part of the subjects to express disappointment in how little responsibility the government takes for healthcare. Subject 2 articulated that "The problem there is with the Haitian government at the health level, it's that you don't feel that health is a priority for them. They more leave the health on the backs of the NGOs," while Subject 4 went further to say:

> I don't know what it would take for Haiti to take on healthcare. To take on even the most simple maternal healthcare. I mean of just saying, here's our country, here's a map, where would we have to have maternal health posts of some sort.

But, she argued, the Haitian government is unlikely to take this on because too many in the government are sustained by the funds they personally receive for involvement with NGO projects and funds.

Even as the government is accused of not taking the lead on healthcare, international development agencies continue to direct most aid away to projects happening outside MSPP's purview. What funding is given to the government is given in pursuit of particular social development goals which, while not necessarily destructive, are far from apolitical. Maternowska (2006) spends extensive time in her research exploring the chain of influence that lead to the vertical family planning interventions implemented in Haiti in the 1990s. "Under pressure from USAID headquarters in Washington, D.C., all official public health endeavors from 1971 onward were to have separate [family planning] components. Haitian programs and project activities were reformulated according to USAID protocols and standards" (p. 141). Farmer (2000) also details an International Development Bank loan to Haiti in the late 1990s for a project to

"decentralize and reorganize the Haitian healthcare system" (p. 314), along what many believed to be a realistic trajectory. Yet IDB withheld the loan in response the the 2000 elections that put the socialist leader Jean Bertrand Aristide back into and 2nd term as president. These instances illuminate that global geopolitical factors prevent MSPP from having autonomous control of its funding or health priorities.

All subjects interviewed expressed a need for MSPP to take on particular health priorities, but had very different understandings of the global factors contributing to its limitations. Subject 4 felt that one of these limitations was corruption, suggesting that many in the government received a cut of external funds. "External funds yeah…it's always this little bit here, a little bit there, I think it's probably billions of dollars." Mullings, et. al, argue that "Racialized discourses of poverty and criminality have begun to emerge in the form of an almost pathological obsession with the issue of corruption" and that these discourses "justify the need for external control of the process" (2010, p. 293). Perceptions of corruption and related mechanisms of external control, while rampant in places like Haiti, are not touched upon in the story of Mrs. X nor the framework of the Three Delays.

6.2 Stakeholder Resistance

Also not examined in the story of Mrs. X are the myriad ways those invested in reducing maternal mortality may resist and delay each other. Harmful or inconsiderate practices on the part stakeholders, including traditional health practitioners, MSPP employees, NGO workers, patients, U.S. clinicians, and international donors, have lead to many conflicting approaches to health. First, the social distancing described by Maternowska, and the cruelty mentioned by Subject 4 speak to a medical system in Haiti still clinging to vestiges of colonialism and classism

that may repel patients from seeking care. Second, minor instances of corruption that arise in low-resource MSPP settings, such as the selling or stealing of donated medications, or the practice of charging patients in poverty for care even in the midst of an emergency, may repel NGO workers from collaborating with established public health institutions. Finally, clinicians from the U.S., often leading private health initiatives in Haiti, may be repelled by highly technical, modern practices that focus on institutional, public approaches rather than individuals in communities.

To see how these stakeholders interact in practice, it is necessary to return to the example of the a C-section conducted without anesthesia described in the previous section. The patient stakeholder in this situation will experience extreme physical pain, will then likely associate this trauma with the hospital and doctors within it, and distrust the medical system going forward, even as she is taught that doctors are infallible (Maternowska, 2006). In many cases, these patients become employee stakeholders in the health system. One SBA employed by MFH also experienced a C-section without anesthesia as a young woman and the instance motivated her to become an SBA to counter such harmful practices of care.

Concurrently, the U.S. clinicians and international NGO workers who witness a painful C-section draw large conclusions about healthcare in Haiti and its effectiveness. They come to resist these injustices and the government health care system that enables them, instead developing independent projects where they pride themselves on more respectful, compassionate practice. An example of this is seen in the famous biography of Paul Farmer, *Mountains Beyond Mountains*. While PIH/ZL today is a fierce advocate for collaborating with MSPP, when the book was written in the early 2000s, it failed to mention government healthcare in Haiti, save one, brief prelude to a longer story: "a woman from the city of Hinche, eschewing the dreadful hospital

there – floors of rotting wood, an open sewer out back, no medicine without cash – brought her son by tap-tap over the road to Zanmi Lasante" (Kidder, 2006, p. 262). Farmer's patients trek hours through the Central Plateau to reach his private, non-profit hospital in Cange where they receive care for free. Readers are not encouraged to consider the geopolitical forces that result in the condition of the Hospital St. Thérèse. The public institutions that do charge for care or who may be practicing post-colonial medicine are resisted and evaded by foreign interveners, just as they might be by low-income Haitian patients (Rapp, 2016).

As patients and foreigners resist post-colonial medicine, so too do the practitioners of that medicine resist interventions from outside their institutional culture. Health workers' resistance may be seen in the common practice of holding one position at a public institution and then spending most of their time at a private practice or traveling to nearby urban settings with better resources. Subject 4 described a general absence of leadership in the community clinic on La Gonave:

> I mean obviously, if the priest, who was the overseer of the whole program had um been willing to drive up into the countryside… in theory he was supervising them… he could have been running the staff meetings, and actually, the doctor, was actually pretty sweet and was not classist. He was from La Gonave and actually really nice. But he had it in his mind that getting a job and going to work weren't necessarily the same thing…. I think he went to Guatemala.

Maternowska also noted that both doctors at the clinic in Cité Soleil "held jobs in other medical practices, and the job in Cité Soleil was really only for the extra cash it brought" (2006, p. 75). A recent article in the Haitian newspaper *The Nouvelliste* states that the majority of Haitian ISFs work in the West Department, and that 40% of these ISFs hold two jobs at the same time. 4%

hold three simultaneously (Magloire Civil, 2014 May 15).

Even as they seek out jobs in institutions and clinics run by a variety of stakeholders, MSPP employees also resist the systems partners implement. In my participant observation at Hospital St. Thérèse, I frequently found that the hospital administration resisted MFH's suggested interventions, and did not appear interested in changing their protocols or reorganizing their schedules to do what MFH believed would improve patient care, despite the NGO's significant financial support of the hospital. When we reported to the hospital leadership that a C-section had be performed without anesthesia, our complaint was dismissed within a few minutes. Different interpretations of the importance of patient care and comfort abound in the Global South. Livingston mentions cases in Botswana where a nurse would challenge hierarchies within the hospital system to "police her own professional autonomy even if this went against a patient's interests" (2012, p. 98). The stakes of work in these post-colonial institutions necessitate that the professional status of nurses, doctors, and midwives often be claimed in opposition to the patients who external organizations might feel most invested in serving.

The above examples can all be seen resisting the dispossession that Mullings, et. al, describe taking place within Haiti's NGO-ization. MSPP employees and administrators in Haiti recognize that discourses around aid to Haiti "disassociate the majority of Haitians from civilization (defined in Eurocentric terms)" and construct "Haiti as a nation that lies outside of modernity and progress" (p. 284). Thus these health workers and administrators may distance themselves from both traditional, community practices of birth, lead by matwòns, and the interventions of individual foreigners that favor a return to more "natural" and "traditional" birth practices over high-technology interventions.

While global health advocates advise that NGOs and other external stakeholders work

within and in support of established public health systems (see NGO Code of Conduct, 2008, and Krasnoff, 2012), there are also numerous reasons why public systems are unable to serve populations in need. In response to harmful practices in institutions, or those NGOs see as harmful, NGO actors may feel their non-formal, community level approaches serve these populations better. While this is often true, NGO approaches are usually unsustainable and do not take into account that international intervention and dispossession is at the root of much of this harm.

6.3 Accountability and Collaboration

Financial and political incentives in the development sector are often aligned so that local populations are the last location of accountability for an organization. While mission-driven NGOs can claim accountability to their mission, these missions can also shift over an organization's lifespan due to environmental, political, or financial reasons, and further destabilize systems and cultures of accountability. In the past, NGOs relied on donations from funders who were satisfied with the service-oriented appeal of their work rather than their actual outcomes. Recently, however, donors have begun to demand rigorous data collection methods to measure and prove the impact and success of their programs. Because these measures are considered to be objective, they establish accountability to both donors and target populations (see Barnett and Walker, 2015). Increased emphasis on data may help an NGO increase accountability to donors and established systems, but may not take into account all cultural worldviews and the local relationships essential to have an impact.

When considering implications for future practice, I could certainly argue that more involvement of communities and Haitian voices is necessary to advance healthcare in ways that

shorten the Three Delays. However, Haitian voices participate in, lead, sustain, and resist both MSPP and NGO approaches to maternal health, and will provide a variety of contradictory perspectives on maternal health. As a result, it is essential that accountability to Haiti and its people be understood as a practice that can be pointed in multiple directions to multiple stakeholder locations.

Subject 1 emphasized this point when she suggested increased funder involvement in health projects in Haiti. A report from the hospital would not be enough, she argued. Instead, funders should visit the site prepared with questions in hand to ask the community. It will be the community, she said, that will tell the organization if the financial support they are providing is being rolled out appropriately. Yet even this model of evaluation eschews listening to the health care professionals at the clinic who may also have feedback for an international funding partner. A community evaluation such as this one risks falling into the trap that all Haitians are relatively disempowered receivers of care, and never providers.

Accountability should not only take the form of reports and evaluations. Subject 4 also spoke of a particularly blatant example of poor follow-up and accountability on the part of medical mission teams to La Gonave that is worth quoting at length:

> So that's what happened the first day I was in La Gonave. They had a visiting team, they had an ultrasound machine, they were doing ultrasounds on women's uteruses who weren't pregnant, they were just doing ultrasounds on uteruses and giving them a picture of their uterus. And um and this went on for two days. So I thought, wow this is a really busy clinic. It's in the middle of nowhere but its really busy. The day after that team left, no one. No one….no one for the days after. Another mission team comes, they get everybody to show up. Who didn't have an illness…. Because they think the way to make

their donors happy is to get you know these crowds of people to come.

It is this same clinic that Subject 4 describes where community members living close to the clinic refused to come for care as a result of disrespect they had received there from Haitian healthcare workers in the past. Even as donors and foreign healthcare providers strive to be accountable to poor Haitians by providing free services to as many people as possible over a short period of time, they fail to hold themselves accountable to Haitian health systems which might imagine medical care enacted in a completely different way.

The aversion to working with government systems and a poor ability to trust Haitian systems creates a shadow delay. While NGOs and the government simultaneously strive to provide better and quicker access to care and address the Three Delays, their unwillingness to try collaborative approaches leaves some regions falling through the patchwork of services depicted in the results of the student survey.

Unwillingness to cooperate actually created further delays in the midst of erroneously reported chaos and anarchy following the 2010 earthquake. Mullings, et. al, write that in the aftermath of the earthquake some groups said their relief efforts were delayed because of the "scale of the devastation" and a damaged supply chain, but that "the delays were also hampered by the climate of fear that made some donors reluctant to distribute aid without security forces present" (2010, p. 284). While responses to maternal mortality in rural Haiti today are not happening in the same post-disaster setting as those in January 2010, donors and foreign involvement continue to dispossess Haiti and Haitians of ownership and accountability in their health and health programs.

Frequently, MSPP is leading evaluations of its own programs and making overarching efforts to strengthen institutional capacity. Subject 3 mentioned evaluations conducted by MSPP

that routinely visit SONUB and SONUC facilities to see the degree to which they are functioning effectively. It is possible that it is as a result of these evaluations that MSPP has decided to direct its resources toward addressing the 3rd Delay. It is also possible that should foreign groups and NGOs participate in these evaluations and understand with more detail the limitations of the healthcare system, they will come to find more focused, sustainable ways to channel their expertise, as in the UNFPA partnership with the SONUB in Marigot. One instance of this was in an NGO-MSPP partnership in with a public hospital in Cap Haïtien mentioned by Subject 4, where goals for a regional hospital were set collaboratively and then assessed collaboratively. Tools like NGO Code of Conduct for Health Systems Strengthening (2008) can also provide guidelines for working with the public sector in way that supports, rather than an undermines public systems.

However, evidence shows that locating joint approaches in institutions alone will not succeed in addressing all Three Delays. Legacies of pain and colonialism persist in hospital and clinic practice in Haiti, and fees for service, medications, and transportation prevent many women from reaching care. Meanwhile, there is a regularly shifting understanding of whether childbirth should be medicalized and treated like an illness or whether it is a natural process that can take place at home with family. These contestations affect the behaviors of Haitian women seeking care, the Haitian government's approaches to health, and the approaches of foreign NGOs seeking to influence health practices around the world.

7. Conclusion

Maternal deaths are happening in Haiti as a result of the Three Delays. Women are reluctant to seek care in formal institutions, and prefer giving birth at home with matwòns. Transportation is difficult, and even rural clinics may take long walks to reach. Hospitals run by private and public bodies do not have the capacity to handle all cases or give patients with the attention they need. Beyond the Three Delays, MSPP, NGOs and health workers do not coordinate or have full knowledge of the geopolitical, historical, or financial dynamics that continue to the effectiveness of their actions to reduce maternal mortality.

Approaches to maternal mortality must be both collaborative and take a broad view of of the barriers to healthcare and safe birth for women in Haiti, not just in the form of the Three Delays, but in the socio-political histories that dispossess key stakeholders from taking appropriate action. Haiti sits at the intersection of global health priorities, local histories of resistance, NGO strategies of community health, and public institutional development. Many argue that care should be socialized, subsidized and public, while others admonish the government and advocate for privatized approaches more attuned to local needs.

Yet these advocates and stakeholders are frequently in the dark about how others are operating and rarely are collaborating. I do not feel that the NGO-ization of Haiti will sufficiently address the Three Delays if these NGOs continue to be oblivious to government initiatives and criticize public approaches operating within severe historical, political, and funding constraints. I see no need, however, to purely rely on building the technical capacity of formal institutions, when less-formal approaches like mobile clinics may be more welcoming toward Haitian communities resistant to government control.

One example from my own work with MFH stands out: one of the busiest sites of the

MFH mobile clinic has been a Catholic Clinic in the town of Cerca Carvajal. The U.S. based Catholic partner had expressed interest in supporting the salary of an MFH SBA graduate to work in Cerca Carvjal permanently, but had neither the international staff on the ground nor the space at the Catholic Clinic to make delivery care feasible. Early on in my time with MFH I was tasked with finding a way to allow the SBA to both work in a nearby MSPP facility with space for births and receive the support of the Catholic partners. I knew that if the work of the mobile clinic was not transferred to the stable SBA appropriately, fewer women would receive care than before.

Ultimately, I was able to start and conclude the process for a five-way negotiation and eventual contract between the MSPP clinic, where the SBA was to see prenatal patients and handle deliveries four days a week, the Catholic Clinic, were the SBA was to see prenatal patients one day a week, continuing the tradition of the mobile clinic, the U.S. Catholic Church Partner, MFH, and the SBA herself. In this joint role, she serves as a gateway for those women accustomed to the mobile clinic who may now be more willing to seek an institutional birth at the MSPP clinic if needed, knowing who their SBA will be. The mobile clinic SBAs were also a key element in the process, visiting again after the SBA was installed to demonstrate a seamless handover of care.

Time will tell if this approach will be completely successful. However, it serves as an example of a multi-stakeholder approach to maternal healthcare that takes into account the ways Haitian women seek support inside and outside of formal institutions. I suggest we imagine further how a health system can include public, private and community approaches simultaneously, and be jointly accountable to high standards of care, global health objectives, and patient relief.

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