COMMUNITY PARTICIPATION AS A RESPONSE TO THE CRISIS OF MATERNAL MORTALITY IN HAÏTI

by

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ABSTRACT

Maternal mortality is an ongoing health crisis in Haiti. Estimated at 523 deaths per 100,000 live births it is the highest rate in Latin America and the Caribbean. There are many factors that influence the dire status of disadvantaged pregnant women in Haiti, such as lack of prenatal care, unsafe and unsanitary deliveries, long walking distance to seek medical care, and inability to pay medical fees. Conditions of ill health such as high maternal mortality can be taken as clear indications of poverty, proxies for the lack of development. It is also argued that this condition is directly related to the lack of community participation, the application of the top-down approach and/or strong external involvement on health policy and health programming in Haiti. However, it has been recognized that economic and social development requires and is predicated on structural change, social transformation or institutional reform.

This study examines the change needed in government policy, in new policy regime supportive of a community-based approach to development and social development, from within civil society and from below, that is, initiated from the grassroots to effectively address this health condition and sustain any health projects in Haiti.

The report of the field study evaluate the extent to which these elements, such as change in government policy, support of a community-based approach to development and social development has been implemented. This report also emphasizes the importance of community participation, mostly the participation of women to tackle this issue.

Marie-Hélène Beauboeuf

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I dedicate my thesis to my sons Kris and Vic. Thank you for your love and support throughout my studies.

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CHAPTER 1

INTRODUCTION

1.1 Posing the Problem

Haiti is a prime target for aid. Crippled by severe poverty, the country has been subject for decades to overseas aid delivered by NGOs, bilateral and multilateral agencies, churches and private donors dealing with diverse issues of development including health. Development projects have been organized by numerous international organizations, Non-Governmental Organizations (NGOs) and by the Haitian medical professional to improve the health situation for the poor and mostly to help reduce the rate of maternal death in the rural areas and the poor urban region of the country. However, despite all the international aid and health development projects over the years, the general health of the population, particularly of the poor, an intractable and disproportionately large part of the Haitian population, over 50% rate, is still deplorable. The rate of maternal mortality, an important condition of poverty and a common indicator of a population's state of health, reflects this situation.

The persistence of poverty as measured in economic or income terms, or in terms of health and other social or basic needs indicators raises a number of questions about the efficacy of the development project and overseas development assistance. One question is whether the structure itself of aid, traditionally top-down with very little community participation, might be a

contributing cause of the apparent failure of the development effort in Haiti? Or is constant political instability a factor impeding all development progress in the country? Also what kind of development effort has been made to specifically address the problem of high rate of maternal death? What have been the results of development aid to Haiti? Have some form of aid been more successful than others? What are the factors of successful or failed programming and aid delivery? Could the lack of continuity or sustainability of these international projects be the factors for the failure of most health development projects in Haiti including health projects for maternal mortality? Could health programming, which has at its core a commitment to community values and well- being, such as that adopted by Sri Lanka and/or Cuba provides a better model for improving maternal and child health?

It is generally understood that economic and social development requires, and is predicated on structural change – social transformation or minimally institutional reform. Can aid effect such change? Has it done so? Is the relative or apparent failure of so much development effort the result of the structure of aid? Is it a question of agency or strategy? Is it a question of misplaced or inadequate government policy? Or is the problem located in the broader economic and social structure of Haitian society? Is this structure simply too resistant to change – not susceptible to development no matter what form this might take?

The first step taken in search of an answer to some of these questions, and thereby an understanding of the dynamics of poverty and underdevelopment

in Haiti, was a systematic review of both the academic literature related to the problem and development programs over the years. Have these questions raised by our reflection on the problem and my own experience as a Haitian by birth and 22 years of life, been addressed in theory and/or practice? If so what answers have been given to them? Have any been settled? My review of the literature is discussed in chapter 2 but my general conclusions can be summarized in brief.

One conclusion drawn from the literature is that health is a critical condition of poverty. In the academic of literature and policy / program analysis / evaluation poverty is most often portrayed as a problem of social exclusion from government program. However, findings has some scholars suggest that the roots of the problem go deeper into the economic and social structure of ownership or the lack of adequate access to society's productive resources. In any case, endemic poverty is reflected in diverse social conditions, particularly health. Conditions of ill health such as high maternal and infant mortality can be taken as clear indications of poverty, proxies for the lack of development. A second conclusion drawn from my literature review is that the relative failure of so much development effort – decades of effort by the international organizations cooperating for development, government of the day and civil society and communities - is due to both structural factors (the economic and social structure of Haitian society) and strategic considerations. In this regard in the 1980s the government of Haiti as elsewhere retreated somewhat from its responsibilities in the areas of economic and social development reaches a vacuum, a gap in remedial programming. With the assistance of a growing number of non-

governmental organizations, this gap was filled by diverse community-based organizations, acting in partnership with the organizations for development, both bilateral and multilateral.

The problem of poverty and ill health have also resisted the efforts of these community-based or grassroots organization in Haiti's burgeoning civil society. These are clear indications that a self-help approach or effective participation of communities in the development process is a critical factor in the relative (albeit limited) successful outcomes achieved in the areas of health and poverty. Another critical factor is partnership with the Haitian government, local grassroots and the international communities in development process. The lack of partnership between the 3 actors makes it difficult for any development projects to be successful or to be sustainable. This partnership could enable local and international partners to share the responsibility in identifying priority needs, designing the response to these needs and acquiring the skills and resources required for the continuity and implementation of that response. In a partnership with the local grassroots the government will recognize and value the skills, resources, knowledge and capacity of their members, and will implement policies allowing them to be included and to participate in the development process (OECD, 1995: 10-13). But as demonstrated in the literature review, such step is yet to be applied in the development process in Haiti in order to see any kind of progress in that regard.

1.2 Thesis Statement

The poor health that so many Haitians face is due to poverty that has plagued Haiti for decades, if not longer. The causes of this poverty are diverse. They include the economic and social structure in the country, which denies the poor adequate access to the productive resources of Haitian's society. Another undoubted factor of poverty is the government's macroeconomic policy, particularly in the neoliberal (structural adjustment) form pursued over the past two decades at the behest of the World Bank and other international financial institutions that have conditioned development assistance on the adoption of market-friendly 'structural reforms'. These reforms, it is argued, have exacerbated and created new conditions and forms of poverty by worsening preexisting social inequalities in accessing society's productive resources; increasing the vulnerability of the poor in regard to forces of globalization; and further marginalizing the poor vis-à-vis available government social services. Under these structural and policy conditions many Haitians and the poor have not only have no or inadequate access to productive resources such as land, capital, technology and employment, but they have lost the safety net that they once had with the developmentall and social welfare state, such as it was.

Both Haitian's entrenched social and economic structure, and the 'economic growth' policies pursued by the government, tend to worsen rather than improve the lot of Haitian's poor, exacerbating their social exclusion and forcing them to rely on their inadequate resources in an economy geared to the

private sector (of profit-making enterprises), and to do so without the support of public institutions. The overseas 'assistance' provided by a host of multilateral (intergovernmental) and bilateral (government) institutions in this context of a market economy cannot overcome or compensate for the structural forces and conditions generated by the existing social structure and government policies. Thus, to give development a chance, there is a need for both structural and policy change. Existing development programs oriented as they are towards poverty alleviation, and neoliberal policy of structural adjustment that exacerbates the problem, cannot provide a solution to the problem of poverty.

The thesis of this study is that a better solution is to be found in community-based development, the effective and full participation of grassroots/ non-governmental organizations. However, community-based development (CBD) and popular participation by themselves cannot solve this problem; effective structural change is needed as well as a fundamental shift in government policy away from what the World Bank mistakenly terms 'pro-poor economic growth' policy. What is needed is a change in government policy, a new policy regime supportive of a community-based approach to development and social development, from within civil society and from below, that is, initiated from the grassroots.

As for the unacceptably high rate of maternal mortality and other such conditions of poverty in the country, it is argued that it is directly related to the lack of community participation and still the application of the top-down approach and/or strong external involvement on health policy and health programming in

Haiti. Therefore, in order to improve maternal health and reduce maternal mortality in the country, three conditions of social change are needed. First, a change in government policy and approach allowing people from all path to be included in decision-making regarding their well-being and livelihood. Second, wide-range community involvement and broad-based community development in all health projects. Third, the involvement of the community in development initiatives and programs, which will bring continuity and sustainability to development and health projects in the country.

In short, the thesis of this study is that a solution of endemic poverty in Haiti requires these three elements, community participation, alternative development and change in government policy.

1.3 Theoretial Framework

To understand how poverty has such a devastating impact on the economy and on the social structure of the developing countries, one must look at the thinking behind development theory and practice over the years.

Over the past 40 years, economists and development thinkers have believed that economic growth was the dominant factor in order to have development. They believed that with growth the economy will lead to wealth, which in its turn will "trickle down" to the poor. For the problem of development some scholars thought that economic growth could transform traditional societies into modern ones (Rostow, 1960). Other development thinkers defined the problem of development by seeing the unlimited supply of labour as a way to

achieve growth (Lewis, 1954). Countries in need of transformation, i.e. from traditional to modern, or in need of growth were viewed as homogenous groups. Therefore, each country was subject to a vicious circle of under-development, which could be broken by a 'big push' coming from foreign capital and know-how (Jazairy et. al, 1993). Developing countries that were following this transformation, their tradition and knowledge, their resources, social structure and political orientation, their historical background, pre-colonial and colonial heritage were not considered. The ability of the local peasantry and artisans also counted for little (Jazairy, 1993 p. 2).

The dominant development paradigm was applied to all developing countries, irrespective of their ability to integrate their economies with the world's economy. In the 1960s and 1970s, trade was an important source of growth in many developing countries such as countries in East Asia and Latin America. These countries opened an open door policy to foreign private enterprise and received substantial amount of money, and with trade contributed to economic growth for a time. However, this kind of economic growth could not be sustained when the external environment was unfavorable and when 'the potential for internally generated growth' such as agriculture was ignored and neglected (Mellor, 1976 and 1986). In some countries, poverty persisted and in some cases worsened between the 1960s and 1970s. There were mostly a wide gap between the rich and the poor, and a large increase of social inequalities. In countries where growth was on the rise, only a small privileged minority benefited from that

prosperity. The most affected was the population at the bottom of the income scale. What thinkers from the old paradigm failed to recognized is that:

> "The old dominant paradigm overlooked the requirement that growth has to serve the rural poor by raising returns to the factors of production owned and/or operated by them and by allocating an equitable share of public resources to providing rural services and infrastructure (Jazairy, 1993 p. 4)".

The idea that stems from this statement is that a "safety net" should be established to protect the most vulnerable of society, the poor. To obtain that safety net, economic growth, essential for increasing a country's Growth National Product (GNP) per capita[1] and essential to alleviate poverty should lead to development with the participation of all segments of the population.

The old development paradigm had known few challenges. First challenge was the 'Redistribution with Growth'. In this context, the poor were supposed to benefit from growth through economic linkages and by direct redistribution of income. This could be done by taxing the incremental income of the rich above a certain level and to redistribute that tax to the poor by way of public expenditure. However, the reality is that such taxation and redistribution is limited in developing countries, therefore "redistribution and growth" could not be realistic in such context (Chenery et al., 1974). Another challenge was the 'Basic Needs' approach made popular by the International Labour Organization (ILO). In this

[1] GNP per capita, the dollar value of a country's final output of goods and services in a year (its GNP), divided by its population.

context, it was suggested that within the framework of growth of GNP, measures should be taken to ensure that the basic needs of the poor are satisfied, i.e. food, clothing, education, health and housing. But the Basic-Needs strategies focused on the consumption needs of the poor rather than their productivity and their capacity to generate a surplus. The basic needs approach in a way was unexplored because it has never fully been taken by the international community or by national government. In this approach, development thinkers persisted that the transfer of resources from the more productive and dynamics sector of accumulation was needed to enhance the economics of the poor. Realistically, assistance to the poor can be achieved, "not as diverting resources from growth, but as adding to it by enhancing the productive potential of an important contributor (Jazairy, 1993)". Therefore, the Basic-Needs approach remains in the dominant theory because it never does call for structural change, but just for the provision of some life essentials to the poor.

Another variant of the dominant paradigm was the debt crisis, for which the financial institutions such as, the International Monetary Fund (IMF) and the World Bank have created 'Structural Adjustment Programs (SAPs)'. The policy of SAPs demands that countries in debt must change their economic policies in order for them to meet their debt obligations. Part of the SAP design is to promote exports to get foreign exchange, while limiting imports by reducing people's income and purchasing power (Oxfam Canada, July 1992). The reasons explained by the IMF to implement their design, is that they have been too much demand by developing countries for imported goods, from food to luxury items.

Therefore, governments in the Third World were not developing their export sectors to generate hard currency or to increase the level of their country's GNP.

Another SAP design is to reduce or eliminate government spending, mostly on social programs. Privatization of public sectors enterprises is also one of SAP's design. Many critics say that privatizing basic necessities such as water and electricity only hurt the poor by preventing them from obtaining potable water and electric power (Oxfam Canada, 1992). Thus, in order to qualify for loans, developing countries would have to conform to Structural Adjustment Programs. The IMF's austere programs consist of these principal provisions such as: deregulation, the privatization of government-owned enterprises, as mentioned above, elimination of tariff barriers to overseas imports, measures to promote export production, devaluation of national currencies to cheapen exports (Griffin, 1989 in "Empowerment, The Politics of Alternative Development, 1992 p.5).

Critics of the dominant paradigm point out that Structural Adjustment and the GNP growth theory have failed to recognize that poverty alleviation and growth are complementary. Concerned with the result of the economic growth theory, the International Fund for Agricultural Development (IFAD) proposed an alternate theory. It proposed that "any programme for growth and adjustment must activate the productive potential of the rural poor rather than focusing on the non-poor and merely providing welfare support for the poor during the 'period of transition' (Jazairy 1988; IFAD 1988b and 1989l)". On the same note, the Bretton Woods Institutions and the United Nations Development Program

(UNDP) have also realized the shortcomings of Structural Adjustment to really reduce poverty in developing countries and have pushed for structural change.

Thus, since 1989 the International Monetary Fund (IMF) introduced the concept of "high-quality growth" in which growth should be equitable and where attention should be paid to the poor and to the protection of the environment. The World Development Report of the World Bank, 1990 introduced the concept of "poverty reducing growth"[2]. The idea behind this concept is that growth should be conceived to reduce poverty rather than increase it. Two pronged strategies were recommended in that Report: a) broad-based economic growth which generates efficient income-earning opportunities for the poor; b) improved access to education, health care and other social services which help the poor take advantage of these opportunities. Also the UNDP through its Human Development Report of 1990 and 1991 has suggested that growth was necessary but not enough to allow human freedom of choice and human development[3]. Therefore, following its 1990, 1991 Report, the UNDP refined its Human Development Index (HDI), which previous to these reports had combined life expectancy at birth, literacy and per capita income into one index. But since

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[2] The World Bank announced its renewed concern with poverty reduction in the 1990 World Development Report, Poverty (World Bank, 1990):
"The evidence in this Report suggests that rapid and politically sustainable progress on poverty has been achieved by pursuing a strategy that has two equally important elements. The first element is to promote the productive use of the poor most abundant asset – labor. It calls for policies that harness market incentives, social and political institutions, infrastructure and technology to that end. The second is to provide basic social services to the poor. Primary health care, family planning, nutrition and primary education are specially important (World Bank, 1990: 3)".

[3] In the 1991 World Development Report it was stated that:
"markets cannot operate in a vaccum – they require a legal and regularly framework that only governments can provide. And, at many other tasks, markets sometimes prove inadequate or fail altogether. That is why governments must, for example, invest in infrastructure and provide essential services to the poor. It is not a question of state or market: each has a large and irreplaceable role (World Bank, 1991: 1)"

the 1990, 1991 Report, the UNDP's HDI take into account factors such as, standards of education attained, gender disparities and income differentials within countries (Jazairy, 1993 p. 12). Surely, this indicated a broadening of traditional views on development.

Critics of the dominant paradigm found strength in the lack of progress in terms of growth and development, equity and human development as predicted by the advocates of traditional economic theory. The gap between the rich and the poor was widening. The failure of the old paradigm to establish that growth by itself could alleviate poverty and improve the life of the poor was evident throughout the developing worlds. Even the international financial institutions, such as the IMF and the World Bank had to admit that there were flaws in their way of thinking. Furthermore, concepts, such as "high-quality growth, "poverty reducing growth" and "human development" combined with the failure of economic growth prompted crucial changes in development thinking.

In the article *Pro-poor health policy in poverty reduction strategies*, (June 2003), the International Monetary Fund (IMF) and the World Bank has announced in 1999 a new set of conditions with regard to debt relief and financial assistance for indebted poor countries (IMF / World Bank 1999a; World Bank 2000). These new conditions required developing countries to formulate a Poverty Reduction Strategy Paper (PRSP), which should present the country's macro-economic, growth and poverty reduction. The PRSP should also describe the external financing needs, the major source of finance and show a participatory approach

(IMF / World Bank 1999a, b, c; World Bank 2000; IMF / World Bank 2001). Countries unable to present a full PRSP at the time of their new lending arrangement will receive assistance based on an Interim PRSP, and the iPRSP should describe the government's commitment to poverty reduction and participatory approach. Furthermore, the iPRSP should sketch a 3 years macro-economic framework and a policy plan including the main elements of the poverty reduction strategy (World Bank, 2000).

This article was a study conducted by a group of health and development analysts to arrive at a systematic assessment to see if the first batch of the interim PRSP really addresses the health of the poor and vulnerable (Laterveer et al. 2003, p. 138-145). In this study, a semi-quantitative approach was used to assess the pro-poor focus of health policies in national documents. This approach was applied to 23 Highly Indebted Poor Countries (HIPC), mostly in Africa, and the focus of the analysis and the findings was on the iPRSP of these 23 HIPCs (Laterveer et al., 2003).

The result of this study highlights some concerns about the process and the potential returns to the health of the poor. These results showed that:

- While all countries included in the study pay attention to urban/rural distribution of poverty, they didn't provide data of geographic distribution of poverty.

- Although 57% of the documents retrieved states that health surveys were conducted, but the poor are rarely mentioned in these surveys. Little attention was paid to data collection regarding the impact services and the constraints. More importantly, the iPRSPs did not outline how the preparation of the full PRSP will address the weakness of the data.

- In documenting health system constraints, only a quarter of the papers (26%) describe the reason their health systems fail the poor. In reference to the health constraints (43%) the most mentioned one were the lack of drugs, medical supplies and health personnel.

- In the health sector strategies for the poor, although 95% have formulated some specific policy measures, only one-third included a detailed timeline for the implementation of the strategy. Up to 70% of the iPRSPs referred to the poor in their health sector strategy, but it did not really imply that these strategies are actually pro-poor.

- In the specific health sector policies, the most frequently mentioned policy components were disease targets, which implies that efforts were taken to reduce the burden of disease (96%). Targeting specific groups such as women, children or the rural population were rated at 78%. Policy to improve coverage and quality of health services were

mentioned by 74% of the group; and improving health indicators and access to health services were mentioned by 65% of the group.

- In the sector of public health expenditures, there were few variations in the detail provided by countries. Three-quarters of the documents addressed the distribution of public health expenditures to a certain extent. Of the 23 HIPCs, 22% indicated their intention of providing detailed information in their full PRSP.

- In the distribution of public health expenditures, only 9% among the Highly Indebted Poor Countries (HIPC) proposed to distribute expenditures in order to increase the personnel working for pro-poor services and to improve the geographic distribution of personnel. Only 9% also mentioned geographic targeting, and only 4% mentioned age-based targeting and targeting by disease (Laterveer et al., 2003, p. 140-142).

Finally all countries mentioned some kind of community participation in the poverty reduction process. Out of the 23 HIPCs studied, only 13% indicated that the poor have been or will be involved in the formulation and implementation of the health sector strategy. All countries also recognized the importance of monitoring and evaluating the poverty reduction strategy, however, only few paid

close attention in tracking the effects of the health sector strategy for the poor (Laterveer et al., 2003, p.141).

Some recommendations have been made in this study. First, countries in their preparation for PRSP need to be more analytical and more evidence-based. Second, countries should be more specific and explicit in their formulation of national pro-poor health policies. It should be included in their formulation: a) an explanation of the adopted health approach, b) long-term and midterm health objectives, c) a detailed timeline, d) measurable indicators and the costing of proposed policies. It was reinforced in the recommendations that "such policies promote actual implementation and facilitate impact analysis (Laterveer et al., 2003, p. 143)".

Following all the controversies and debates about economic growth and more recently the pro-poor approach by the World Bank, a massive shift took place as development thinkers started to realize that people themselves should be involved in the process of development, as the key focal point of all development theory and praxis.

This development thinking known as "Another Development" has been popularized by the 1975 Dag Hammarskjold Foundation and the magazine Development Dialogue. It has been argued that all the alternative approaches toward Another Development constitute in fact a 'new paradigm'. Thus Another Development would be:

Needs-oriented, which is geared to meeting human needs, both material and non-material.

Endogenous, that is, coming from the heart of each society, which defines in sovereignty its values and the vision of its future.

Self-reliant, which means that each society relies primarily on its own strength and resources according to its members' energies and its natural and cultural environment.

Ecologically-sound, that is to utilize rationally the resources of the biosphere in full awareness of the potential of local ecosystems as well as the global and local outer limits imposed on the present and future generations.

Based on structural transformation required in social relations, in economic activities and in their spatial distribution, as well as in the power structure (Ekins, 1992 p. 99).

Another important aspect of Another Development is that it seeks the Empowerment of Households and their individual members[4]. Friedmann explains that households to further their pursuit of life and livelihood dispose over three

[4] Households can be defined as a residential group of persons who live under the same roof and eat out of the same pot. Each household takes part in daily process of joint decision-making. Households do collectively produce their own lives and livelihood, and are essentially productive and proactive units (Friedmann, 1992, p 32).

kinds of power, which are social, political and psychological. *Social power* is mostly concerned with certain 'bases' of household production, such as, information, knowledge and skills, participation in social organizations and financial resources. With regard to people's participation in social organizations and financial resources, UNRISD reinforces that point by stating that: "the inclusion of local people would increase efficiency leading to the improvement of development (Excerpt from chapter 1: The Quest for Another Development, 2001 p. 9*). Political power* is concerned with the access of individual household members to the process on how decisions regarding their own future are made. In a way, people should be more involved in that process. *Psychological power* is described as an individual sense of potency, which is reflected by the individual self-confident behavior. This psychological empowerment can result from the group or individual's successful action in the social and political domains, and that sense of potency issue from that successful action will have positive effects on a household's continuing struggle to increase its effective social and political power (Friedmann, 1992 p. 33). Thus, the concept of Another Development (AD) seeks the empowerment of households and their individual members through their active involvement in the social and political realm of development.

Another idea stemmed particularly by the United Nations Research Institute for Social Development (UNRISD) was instrumental to the new theory of AD, which is the concept of participation. In the view of UNRISD the disadvantaged from developing countries should participate actively rather than passively – meaning that they would achieve great capacity in order to control

their own livelihood and to have a voice in the shaping of development. The scholars and practitioners associated with UNRISD also argued that the real issue of people's participation is the redistribution of power – through participation implies the redistribution of power over to the powerless (Stiefel and Wolfe, 1994 p. 3-4). Ghai described participation as a process of empowerment of the deprived and the excluded. He elaborated by saying that this view is based on the recognition of differences in political and economic power among different social groups and classes. "Participation in this sense necessitates the creation of organizations of the poor, which are democratic, independent and self-reliant" (Ghai, 1990, from UNDP's Document, p. 3).

Many advocates and researchers of the concept of participation shared this view that people should construct their own development on the basis of autonomous action of community-based local or grassroots organizations. They also argued that development be participatory in form, human in scale and people centered, and that participation must be initiated from within the society, from below.

> "Participatory development is seen as a strategy to be implemented not from above and the outside but from below and within, that is, with the agency of community-based or grassroots social organizations. In this view, people need to be incorporated into the development process front and center and from the outset-in defining the problem, identifying possible solutions and finally taking action" (Veltmeyer and O'Malley, 2001).

Over the past 25 years different forms of development practices emerged and were elaborated particularly in the form of popular or community participation. This shift characterizes the need of the community to participate in the development process and in the decision-making. This is the "participatory development", which many international agencies, non-governmental organization, grassroots organizations and governments from development countries including Haiti are committed to enforcing and implementing in their development practice.

For the sake of the analysis to follow, will now elaborate on some of the main concepts of Another Development, namely the concept of community, the concept of participatory development, of human in scale and people-centered.

A) The concept of 'community' in the context of Another Development is intertwined with concepts such as 'the base', 'local' and 'popular participation'. The term 'community' is defined as a sense of bound between people, a sense of social identity, of people's sense of belonging and mutual obligation as well as shared institutional practices. The term 'local' is used in the context of instituting a form of development that is people-led and participatory (Veltmeyer, 2001 p. 20). However, Veltmeyer has underlined the problems that come with the term community during development projects. For instance, certain conditions are needed to have a real community. First condition is 'small size'. A real human community requires that members of that community know each other and interact directly, and not through the Internet without boundaries across time and

space. This direct interaction can only be applied in small towns and rural communities, and this small size of community is more prevalent in rural areas (Veltmeyer, 2001: 35). Second condition is the homogeneity in the 'social structure'. The dominant class or the élites who own and control the means of social production, social finances and the wealth live in large cities and dissociate themselves in term of class and boundaries with the people in the rural areas. Therefore, the term of community is very difficult to define in development projects because the gap between the two social groups is too extreme to form and represent a real community. In this context, the term community is seen only as "a bounded unit of people that relate simply to administrative or analytical convenience or geographical contiguity (Veltmeyer, 2001: 21). Despite problems encounter by development practitioners to define the term of a real community, the concept that people should construct their own life and that development should be participatory in form, remains the basic principle of the new paradigm, Another Development. This theory of development from below and within, which has as its core a commitment to participation, is the theory, which will guide the rest of the thesis.

B) The concept of participatory development from the perspective of Another Development has to come from within and below and not from above or from outside. This concept can be achieved through community-based or local grassroots. The idea behind this concept is that people need to be included entirely into the development process, meaning that they need to define their

own problem, identify the possible solutions, and finally to take action (Veltmeyer, 2001: 14). In the process of participatory development, people must also feel that they are contributing themselves to their own human, financial and material resources, and should only receive assistance from outside only for things they cannot yet manage themselves. In order to obtain that sense of belonging and self confidence to reach that goal, people should receive training, which in turn will enable them to gain access to resources and services, and to become self-reliant (Burkey, 1993: 50).

Participation also includes the involvement of people in matters that affect them. It is a process, a value and a right (Joseph, 1997: 70). In addition participation gives some empowerment to people, mostly it empowers them in the process of decision-making. In participatory practice, people should be involved in any development projects from the design stage through monitoring and evaluation. A mere consultation of the people should no longer be considered sufficient, nor participation should be limited to the implementation of activities designed from the outside (OECD, 1995: 10). As stated by Burkey:

> "Participation is an essential part of human growth, that is the development of self-confidence, pride, initiative, creativity, responsibility, cooperation. Without such a development within the people themselves all efforts to alleviate their poverty will be immensely more difficult, if not impossible. This process, whereby people learn to take charge of their own lives and solve their own problems, is the essence of development (p. 56).

Participation needs to be fitted into the apparatus of development administration, with decentralized decision-making supported by decisions at intermediate and central levels. Participation is not just another implementing technology. It represents a whole new philosophy of development that leads to

new policies, new roles and new relationships. The participatory approach is more 'democratic' than the top-down model of development.

Another strategic objective of participatory approach of Another Development was the incorporation of women in the development process. During the era of the dominant paradigm women were excluded from the development process. By not having a voice in this process and by not participating in any development projects, women have lost their credibility as economic assets to the family and to society (Joseph, 1997: 63). As some literature has demonstrated, women in developing countries have always been great contributors to the economy of their country. Agriculture and small enterprises, such as street merchants and other entrepreneurial activities are areas where women in that part of the world have surpassed themselves, and have contributed to great extent to the economic growth of their country and to the well being of their family. "Women are entirely responsible for the household economy, organizing the family, raising children, working in the fields and gardens. 90 per cent are involved in some form of commercial enterprise, and spend most of the day at the market, which they reached on foot or by donkey (Larosiliere, 1988: 16, excerpt from "Haitian Woman, the Pillar of Society").

Nonetheless, government, economists and development scholars have always failed to recognize women's values and contribution to society. Women have been excluded from development projects and have been denied any social, political and financial advancement. During the period of the dominant

paradigm, most efforts and strategies for new development perspectives have been carried out or planned by and for men with little concern for the role of women in these efforts. However, with the shift in the development thinking, many development scholars have expressed the need for the visibility of women and their participation in the development process. Thus, in the 1970s scholars of Another Development have led the ideas to incorporate women, members of diverse and disadvantaged or marginalized ethnic groups and the poor into the development process as active participants and not as victims (Velmeyer, 2001: 13). The first formulation of women's participation in this development process was carried on by Boserup, and by her feminist perspective of Women in Development (WID). Her work served as a catalyst to bring women to the forefront of the development discourse. She examined women's role in economic development in early 70s, and found that a majority of the projects during that time ignored women and furthermore, in such projects as technical schemes, women's economic opportunities were actually undermined (Boserup, 1970: 15).

Boserup's work also demonstrated that development projects were not helping women in the Third World and in some cases, these projects contributed to the deterioration of women's status and their exclusion in the development process. Boserup attributed this negative impact on women to Western male bias in development planning, and to the lack of knowledge of the West on the economic and the agricultural roles of women in the Third World. She also blamed the inequality, which exist between men and women (Plewes and Stuart, 1991: 112). Thus according to the WID's concept, the solution was to integrate

women into the "mainstream of economic, political and social life", and to enforce women's equality with men. The United Nations Children's Fund (UNICEF) have also recognized the multiple roles that women play as mothers, food and income producers, as household managers and community activists, and have prompted the importance of including women in the development process for the benefit of the community.

> "By helping to legitimize women's views in the formal decision-making sector and by supporting their self-development and actions for improved family, community, and national welfare, UNICEF aims to strengthen women's self-reliance and society's recognition of the importance roles women play (World Bank Discussion Paper, 1992 p. 64)".

C) Two major concepts have also contributed to the development of the new paradigm of Another Development, namely the concept of the People-Centered Development (PCD) and the concept of Human Scale Development. Elaborated by David Korten, the key to PCD is popular participation. Members of PCD insist on the need to place people at the centre of the development process. People must participate in the decision-making processes that affect their lives, and their participation as the primary development resource to their material and spiritual well being (Korten, 1984: 201). In order for the concept of PCD to be efficient, the initiative must come below, and it requires people's integration into the power structures. In other words, the demands of community groups and civic organizations to have direct control over local resources and a voice in national policy debates. It must also be recognized that any authentic approach to participation must respect the traditions and desires of the target population, and must involve the substantial transfer of power to that population.

Human Scale Development as conceived by Manfred Max-Neef, argues for a form of development that is human in scale, which is based on a balanced between and integration of human values and natural limits (Veltmeyer, 2001 p. 6). Max-Neef has also created a taxonomy of human needs and a process by which communities can identify their wealth and poverty according to how these needs are satisfied. He classifies these needs as being: subsistence, protection, affection, understanding, participation, recreation (in the sense of leisure), creation, identity and freedom. Max-Neef defines Human Scale Development as "focused and based on the satisfaction of fundamental human needs and on the generation of growing levels of self-reliance. He also defines it as the construction of organic articulations of people with nature and technology, of global processes with local activity, of the personal with the social, of planning with authority, and of civil society with the state (Max-Neef et al, 1987 p. 12)". His purpose with the development of the Human Scale Development is to develop the potential role of the social actors, to develop the social participation of local communities, and to basically empower civil society.

Proponents of the participatory development concept expressed their concerns on the considerable gap between the theory of participatory development and its actual practice. They explained that highly centralised and authoritarian political regimes tend to thwart the emergence of participatory approaches. They went on to explain that people who are exposed to administrative arbitrariness or violence usually prefer to avoid the risks in organizing themselves by fear of reprisal. Also

under a regime of centralised and authoritarian political government, the distance between the centres where decision-making are made and the rural population is often out of reach, and constitute an obstacle for the people, mostly the excluded to participate in any decision-making. The lack of education and management skills of the poor also cause obstacles to popular participation in development projects (Flores Saenz in OECD Document, 1995 p. 12). According to Stiefel and Wolfe (1994 p. 212), one of the reasons for the obstacles of participatory development in this context is that governments are not 'neutral administrative bodies' but are the forum for the dominant social forces of the country, the élites. Therefore, the governments resist any policy that entails distribution of power, and resist the concept of participatory approach, which its policy consists of the empowerment of the excluded and their participation in decision-making.

The solution proposed by the proponents of participatory development is that democratisation and decentralisation are keys that could improve participation. Another key factor that they proposed is that democratisation and decentralisation must be accompanied by conditions that characterized participatory approaches. These conditions are "the building up of confidence among the various actors (the marginalized: women and the poor) through dialogue and responsiveness, and readiness to share power and to combine local resources with administrative resources and procedures. The strengthening of capacities of the population through training in a participatory mode which integrates traditional knowledge is another condition that could improve the participatory development process" (OECD, 1995:12).

1.4 Methodology

A qualitative research methodology is more conducive to my field research in Haiti because it deals with social issues. Therefore, my research method will be interviewing, meetings and observation. The objective of my field research is to obtain: a) the most recent statistics and records on maternal mortality in the country; b) to look at various maternal programs, health education and projects which has been developed by the Ministry of Health and has been made available to local health institutions to improve women's health in the country, mostly in the rural areas in order to tackle this crisis; c) to look at some health strategies that were put together by health institutions or by the Ministry of Health facilitating the community, mostly women to be actively involved in health projects concerning them or, some health strategy enabling them to be actively involved in the decision-making process in projects concerning their health; d) to understand why the rate of maternal mortality in Haiti is rapidly increasing despite various maternal projects and help coming from the international community.

The primary sources of information will be obtained from visiting the Ministry of Health in Haiti to look at data, statistics and records on women's health in the rural areas; from interviewing government officials on any recent health programs and health education programs they have developed addressing the issue of maternal mortality in the country and promoting women's health; from interviewing the medical and administrative personnel of Hôpital Sainte Croix of Léôgane to know about the cause of maternal mortality in the regions and to

know about the type of health programs they have developed which focuses on improving the health of pregnant women living in the region. Hôpital Sainte Croix is the institution that has gladly accepted to host my visit in the region and has accepted my request for interview. The primary source of information for my thesis will come also from interviewing pregnant women from Léôgane about their living and health conditions, and the type of health services and programs that have been made available to improve their health.

Semi-structured interview in an informal setting will be used to interview the government officials, the administrators and the medical personnel of the Hôpital Sainte Croix.

Semi-structured interview in an informal setting will be used also during my interview with the medical professional of the hospital when asking them about the outcome of any health programs and projects they have implemented for pregnant women in the Léôgane area, and information about the participation of the community, particularly women's participation in the decision-making process of these projects.

Focus group interviews will be used to gather information from the women of Léôgane.

I will be present during some of the meetings between the doctors and the health agents, and I will ask questions after their meeting. A field research on such an important issue is mostly beneficial to my thesis.

However, ongoing political uprising and insecurity in the country will constitute an obstacle for the field research. Great cautious is to be applied

during traveling and during the period of the research, in particular in the wording of my questions when conducting the interview. Traveling in certain region of the country is very dangerous and interviewing government officials could be seen by some as intruding in the State's affairs, which could imperil my safety in the country. It is a known fact that the people of Haiti show more tolerance and acceptance toward foreign scholars or researchers who come to the country to conduct their Masters or PhD research. Unfortunately, this same tolerance and acceptance is not applied toward fellow citizens who come to the country for the same purpose, and reactions toward them is totally different. The division of class, which is still deeply embedded into the Haitian society, creates tension and mistrust among the citizens. Therefore, questions coming from fellow compatriots, particularly when they live abroad are perceived as a threat or as an intrusion in their activity.

As secondary sources of data collection, a library research will be conducted to obtain documentary records, government reports and academic studies accessed through library or through the Internet. Books, articles and documents written by participatory development scholars and researchers on community development in health will be the main source of information and data used to answer to the questions raised in this thesis. Recent UN Reports on Haiti also the WHO and UNICEF Health Reports on Haiti are used for the purpose of my thesis. Other secondary sources of data are information that I gather from my library research on various health projects on maternal mortality developed by

various international organizations and international NGOs in Haiti. With regard to the secondary source of information, I was not always successful with my research. Through my research, I have made aware that numerous organizations and bilateral donors have conducted many health projects to address the issue of maternal mortality in Haiti. Therefore, I have contacted these organizations and donors by email requesting information and documents with regard to their projects in Haiti. Some of the project coordinator from whom that I have requested some information for my research, kindly provided me with the information needed. Unfortunately, others were not as receptive, such as many prominent international organizations and NGOs that are well established in Haiti for decades and have delivered health care services throughout the country and, according to their website, have developed specific health programs and activities to reduce the rate of maternal mortality in the country. They simply ignored my request, and never answered my email. It was very difficult to find updated data on health care system in Haiti. Health reports and statistics issued by Haiti's Ministry of Health, reports obtained in the library are not current. The information found, is dated from the1980s, which gives inaccurate data on the real health situation in Haiti. Therefore, for more accuracy, I gathered most of the data and statistics on Haiti's health care from the UN, PAHO, WHO and UNICEF health reports.

1.5 Structure of thesis argument

Chapter one poses the problem of the thesis, demonstrates the evolution of various schools of thoughts of the 1950s through the 1980s in the development process, and demonstrates that from these schools of thoughts a shift in the development thinking occurred in which stemmed the concept of community participation, concept that constitutes the main study of the thesis.

Chapter two is the literature review on poverty and health and community participation in health. The literature of this chapter focuses on few countries, which have successful results in their health care system through a community participation program and a progressive health care policy.

Chapter three brings to the thesis an overview of the economic development in Haiti for the past two decades, and demonstrates the detrimental effects of political unrest on the health care system and on any health development projects in the country. This chapter also brings to the thesis the specific cause of maternal mortality in Haiti, and analyzes the government health policy and program and structural changes to address this issue.

Chapter four looks at the work and involvement of non-governmental organizations (NGOs) in the Haitian health care system for the past two decades, and their commitment in implementing various health and maternal projects developed and implemented by local and international NGOs in the country. The McMaster and Université d'Etat d' Haiti Tier 2 Project on reduction of maternal mortality, International Child Care project on maternal mortality in Haiti will be

analyzed. Other maternal health projects developed by Care Foundation, Global Health Action will also be elaborated.

Chapter five is the report on my field research in Haiti: information gathered from interviews and meetings with governmental officials and with the medical staff from Sainte Croix hospital, my host institution, and report on observation during my site visit in Léôgane, Haïti.

Chapter six provides a general conclusion of the thesis.

CHAPTER 2

HEALTH POVERTY AND COMMUNITY PARTICIPATION IN HEALTH, A REVIEW OF LITERATURE

As stated in the publication *Dying for Change*, collaborated by the World Bank and the World Health Organization, "Poverty is the number one killer in the world, mostly in the developing world, and poor people bear a disproportionate part of the global burden of ill health" (World Bank, 2001: 2). The former UN Secretary General, Kofi Annan stated in his 2001 address to the World Health Assembly: "The biggest enemy of health in the developing world is poverty" (World Bank Report, 2001: 2).

In this publication, the first point that has been argued is that poverty creates ill health because it forces people to live in deplorable environment with no sanitation, no clean water and no descent shelter. These conditions in turn make people sick. Poverty creates hunger, which affects people's nutrition and makes them susceptible to disease. Furthermore, poverty denies people access to reliable health services and affordable medicines. It also creates illiteracy, which leaves people uninformed about their health and unaware of the health services available to them (World Bank, 2001: 2).

The second point that has been argued is that poverty and ill health are closely linked. The devastating effect of illness on people reduces household savings, it lowers learning abilities and it reduces productivity, which leads to a diminished quality of life. All of the factors mentioned above create and perpetuate poverty. Hence, the poor are exposed to personal and environmental

risks by living in unhealthy conditions. They are malnourished and are unable to access quality health care services therefore, are more at risk to be exposed to illness and disability (World Bank, 2001: 23).

Health inequities are other factors that link to poverty. According to poverty reduction and health improvement's advocates, the issue of health inequities if addressed by governments or policy makers can improve health and offer a better chance to reduce poverty. They argued that health inequities exist mainly because people have unequal access to society's resources, which include education, health care, job security, clean air and water. They also argued that health inequities are a matter of social injustices, which can be avoided if effort is made to bring changes and overturn this social condition. Hence, "Systems characterized by widespread corruption, violence, endemic racism, gender discrimination and the absence of democracy are breeding grounds for inequities in health and other social spheres" (Swedish International Development Coorperation, 6). Consequently, these poverty reduction and health improvement's advocates argued that health inequities are not only subject to injustices from the health care sectors, but it also reflects the unjust form of arrangements in other sectors such as education, labor and finance (Swedish International Development Cooperation Agency, 6).

Some commentators in the issue of health and poverty believe that the most health-damaging effects of social inequality are those that exclude people from taking part in society, denying them self-respect and dignity. They also argue that the negative health effects of social exclusion are increasingly

recognized – the exclusion and powerlessness that comes with lack of money, lack of education and lack of influence. Therefore, to challenge the issue of poverty reduction and health improvement is to open up opportunities not only for people with the loudest voice, but also for the people with the greatest needs, and at the same time build up conditions in society that offer greater mutual support (SIDA, 15). Factors such as mobilizing the financial resources are needed to improve access to health care, the allocation of these resources equitably relative to need must also be considered. Furthermore, the proponents of poverty reduction and better health state that: "A key principle of health equity is that resources should be allocated according to needs, regardless of ability to pay" (SIDA, 15).

In addition, advocates of poverty reduction and better health argue that in order to tackle the issue of poverty and health, health should be placed at the center of any policy making in the development process instead of being the by-product to improvements in the overall economic performance. They also argued that it is important to ensure that country's economic growth is distributed equitably, and it is important to tackle problems of social inequalities in order to reduce poverty and improve health outcomes. Therefore, spending on health and other social sectors such as education should be recognized as an investment. Policies securing social safety nets are also needed to protect the poor from both the impoverishing effects of ill health and from economic 'shocks', which entails lost of income due to unemployment, loss of assets due to natural disaster and currency devaluation (World Bank Study, 2001: 23).

Wolf in his article, *Development in Poverty Reduction Strategies: An Analysis of the Contribution of Participation* (1984) observed that the concept of popular participation is the adoption of measures that would enable ordinary people to share their capacity fully in the development process. The emphasis of popular participation in the United Nations thinking was formalized with the publication of two major documents. The first, *Popular Participation in Development*, published in 1971 reviewed the emergence of the idea with reference to community development in the Third World during the preceding 25 years. The second, *Popular Participation in Decision-making for Development*, published in 1975 offered a formal definition of the concept with reference to its implementation. The publication of these two documents was the subject of a major research programme into popular participation by the United Nations Research Institute for Social Development (UNRISD).

However, a more significant contribution to community participation came from agencies such as UNICEF and the World Health Organization (WHO) in the adoption of the UNICEF/WHO Declaration on Primary Health Care at the Alma Ata Conference in 1977, "Health for Everyone by the Year 2000'. The declaration emphasized the provision of basic services in local communities, such as basic health care, prevention services, maternal and child health. Above all it called for the mobilization of local communities to take responsibility for their own health ("Declaration of Alma Ata", http:// www. euro.who.int/About WHO/Policy/ 20010827_1).

Through the influence of the international agencies, the governments of many developing countries have acknowledged the need for greater emphasis on community-based development strategies, and some have taken steps to strengthen participatory elements in their social development programs. Nevertheless the steps taken by these governments to strengthen participatory elements in their social development programs were not really conducive to encourage the community's involvement as such, particularly the involvement of women in their development strategies.

As White (1982) stated in his article *Why Community Participation*, participation has an intrinsic value for participants, meaning that the people would have a voice in the decisions that are taken and they would take part in their implementation. Another point he added is that participation leads to a sense of responsibility for the project, meaning that when people have taken an active part in the planning and implementation of a project, they will collectively consider the completed project as their own (White, 1982: 25). Also he stated that participation ensures things are done the right way, meaning that if the people take an active part in the planning and design of the systems they will use, then the systems will be better adapted to their needs than if the solutions were coming from outsiders without consultations (White, 1982: 28).

2.1 Community participation in health

Since the 1970s, the right to health has been recognized as a fundamental human right. This right that has been emphasized by the Declaration of the Alma Ata International Conference on Primary Health Care in September 20th, 1978 and formally presented by the World Health Organization and the United Nations Children's Fund (WHO/UNICEF 1978:34). The Declaration stated that:

> Health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

- People have the right and duty to participate individually and collectively in the planning and implementation of their health care.

- Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures.

- Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community

through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

- Primary health care reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities, and is based on the application of the relevant results of social, biomedical and health services research and public health experience.

- Primary health care includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning.

- Primary health care involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, food, industry, education, public works, communications and other sectors.

- Primary health care requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate.

- Primary health care relies at local and referral levels on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

- All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. Governments should exercise political will to mobilize the country's resources, and to use available external resources rationally (http:www.euro.who.int/About WHO/Policy/20010827_l).

Since 1978, the Alma Ata Declaration has been embraced by all nations and by many non-governmental organizations (NGO's), who have accepted the concept of Primary Health Care (PHC) as the basis for their health care system

(Susan Rifkin, 1986, p. 240). This concept has not only shifted the method and approach of existing health care delivery in which medical professionals defined and dominated the health care system, but has emphasized community participation as the 'heart of primary health care' (Ahmed, 1980: 240). Thus, as stated by the WHO, "the Alma Ata Declaration was henceforth forged as the cornerstone of the strategy to achieve Health For All by the Year 2000, namely primary health care (Zakus and Lysack, 1998: 1)".

Haiti is one of the countries that embraced this Declaration. In March 1996, the Ministry of Health introduced a health policy that recognizes a fundamental right to health and the State's obligation to guarantee access to health care for all (Haiti: Basic Country Health Profiles, Summaries 1999: 11). In its Health Sector Reform, the Ministry of Health defined these priorities:

a) Developing primary health care aimed at delivering a minimum package of health services to the population including a comprehensive health care for women with emphasis on pregnancies and reduction of maternal mortality.

b) Strengthening health promotion activities to encourage the population to assume responsibilities for its health and adopt a healthy lifestyle (Haiti: Basic Country Health Profiles, Summaries 1999, p. 11).

Another view by Nickson (1991) on community participation in health is that the strengthening of community involvement can become effective only when the authorities of the health district are ready to discuss the ideas and concepts of community and to give appropriate support and education. He also stated that if a 'paternalistic community participation' approach is used, the

community could view it as not enough opportunity to put forward their ideas. Consequently, freedom may change into discontent, and inevitable political struggles for the right of self-determined health care will follow (Nickson, 1991: 77). He then went on to propose some strategies for the success of community participation in the Primary Health Care (PHC) concept. For successful community participation, the community must be able to recognize and define health as an important concept. The community must be responsible for discovering its own health needs and the priorities of these needs. Some resources must be made available to assist communities establish strategies and working toward meeting their health needs. Finally, he proposed that the process of health care be an integral part of the district health authority as well as the local administrative authority (Nickson, 1991: 77).

Lynn Morgan argued that with this concept of community participation in health, attainment of good health was thought to center on concepts with an underlying democratic vision – concepts such as empowerment, health promotion and collective action (Morgan Lynn, 2001: 221).

To reinforce the concept of community participation in health, the WHO and its member government launched a campaign to revive the interest in wellness, in prevention of illness and local control of services to improve people's health. Following this campaign, many developing countries adopted community participation as the means to address important health problem. Therefore, it is a strategy that provides people with the sense that they can solve their own problems through collective action (Zakus and Lysack, 1998: 1, 2).

Cultural influence has been emphasized as having a great impact on community participation in health (Linda Stone, 1992). She stated that in order for community participation to be materialized, knowledge of local social culture and leadership patterns was mandatory. Local culture should be viewed not as an obstacle but as a potential resource for health development and programme (Stone, 1992: 410). The positive outcome is that, understanding and accepting local culture in health programmes and development encourages an encompassing framework where all levels of a health system can be incorporated. It also offers a breakthrough in the barrier between local village people and outside developers (Stone, 1992: 413, 414).

I will briefly describe some lessons learned in health projects establishing effective or ineffective community participation. The first lesson learned was from a community health project in Haiti. This project pilot took place in the southern region of the country to contribute in promoting improved health in the rural population and to provide ordinary health services, especially to mothers and children (Méchin, Bernard 1978: 4). Part of the project was aimed at distributing information and providing technical, material and financial assistance to government programs of maternal-child health, family planning, nutrition, medical and sanitary education in this district. The implementation of this project was centered on community participation and to encourage the population involved to actively participate in the implementation by explaining to them that this was their project and it was up to them to ensure its continuity. Many local resources, such

as healers, councils, leaders and other community institutions were recruited for the project (Méchin, 1978: 4). Those recruited received training to increase their effectiveness and competence, and help to disseminate health and hygiene. The outcomes were positive. People who participated in the project implementation were made aware of the benefits of community activities and development. They have seen their contribution in the formation of others. Some of them took the initiative to join force to undertake regional projects, such as road construction, fighting erosion and deforestation or establishing a community school (Méchin, 1978: 5). The draw back in this project is that they were a lack of motivation and cooperation of some populations who became skeptical because of the frequent absenteeism of the medical personnel. As soon as visits from the medical personnel became irregular, community animation became very difficult for both, family planning and nutrition programs. Therefore, the key to community participation that was drawn from this project is to obtain the participation of all concerned, from the targeted population to the medical personnel and community officers (Méchin. 1978: 5).

The second project called "Community participation in externally funded health projects: lessons from Cambodia" (Jacobs and Price, 2003), was done in Cambodia where two externally funded NGO implemented health projects. This project was implemented in accordance with the Cambodian national guideline on community participation and the second project, using lessons and experiences learned from the first one, worked with Buddhist pagoda volunteers. The primary research was conducted in both settings to assess the effectiveness

of the two participation strategies, and the main objective of this project was to identity the most appropriate actors and strategy for initiating community participation in externally funded health projects (Jacobs and Price, 2003:. 399-400).

The result of this project study shows that in order to have effective community participation in external funded health projects, engagement with existing community-based organizations and agencies is required (Jacobs & Price, 2003: 408). In this case, Theravada Buddhism is the dominant religion in Cambodia and pagodas volunteers represent such an organization. Pagoda volunteers are highly respected and esteem in the community, which make their involvement in health initiatives more effective. Their commitment makes the initiatives more sustainable than newly and externally established community structures with formally elected representatives. Therefore, based on the result of this study in Cambodia it is recommended that programmes and agencies wishing to implement community participation strategies in health should apply participatory research to identify the most appropriate local organization to lead such initiatives (Jacobs & Price, 2003: 409).

The third lesson learned from the project "Dynamics of participation in a community health project" (Kelly and Van Vlaenderen, 1996) was a Community Health Project in South Africa, where there was a need for transformation of existing public services, and community participation was required in the implementation and planning of new services. The concept of community participation in this case has replaced the system of unilateral, government

dominated public service policy formulation and implementation, and apartheid during that time. The aim of the project was to assist communities in addressing health issues identified by people in those communities (Kelly & Van Vlaenderen, 1996: 1236). As data analysis, the 'reading guide' method was adapted for the interview material. Out of this data analysis, four modes of participation emerged. In mode one, "Participating from the Perspective of Having Organizational Resources and Special Project Skills", participants perceived themselves as being in leadership roles because of their skills (Kelly & Van Vlaenderen, 1996: 1238). In mode two, "Participating as a Representative of a Non-Community Based Institution Motivated to Participate in the Project", in this category the participants felt encouraged by their institutions to participate. They believe that the project would give them resources good for them and the community (Kelly & Van Vlaenderen, 1996: 1239). In mode three, "Participating from the Perspective of Identifying with the Group Black Township Community", the participants are defined as having the 'needs' to be met. They were seen as the 'black marginalized' with needs to be met. Because of this perception, these participants felt awkward about participating. They thought that they were being involved in a project that serves the interest of the powerful groups. They also felt the need to have more skills, and because of this lack of skills they could not participate actively in the project. Therefore, they had to let the participants with more skills to take charge of the project (Kelly & Van Vlaenderen, 1996: 1239). Finally in mode four, "Participating from the Perspective of Trying to

Co-ordinate the Process and to Bring Coherence to the Project as a Whole", participants were the employed coordinators and the steering committee. They saw themselves as mediators between those who fund and the project. They did not participate in specific parts of the project.

This mode of participation categorizes each group of participants and influences the perspective that they have toward one another. For instance, mode one participants were in an ambivalent position. In one hand they were viewed as being resourceful because of their skills, but in the other hand they were mistrusted because of their tendency to dominate the process, which was reflected in their active participation in groups' discussion (Kelly & Van Vlaenderen, 1996: 1240). Mode three participants in their side were being overly sensitive. They were "self-conscious in their identification with black people and were aware of the black-white dynamics that were present at all levels of the project" (Kelly & Van Vlaenderen, 1996: 1240).

In conclusion few points were suggested in order to avoid this kind of problem in a project and to create an environment conducive to participation. It was suggested to create a capacity-building type of project, which enables people to participate actively in a development process. An assessment of needs and interests should be required to allow better transparency among the group participant, and eliminate any ill feeling among the groups. Finally the context in which the research project was done should also be considered. In this latest case, the social and political contexts in South Africa, such as apartheid should

be looked at closely to avoid the negative perception that existed among participants (Kelly & Van Vlaenderen, 1996: 1244).

Nevertheless, some countries like Cuba has maintained good record on its health care programs with active community participation. In Cuba, health care is considered a human right for all citizens and the country's health policy emphasizes prevention, primary care and active participation of the citizens. The implementation of these emphases highly ranks Cuba's health indicators, despite its economic struggle (Demetrius S. Iatridis, 1990: 29). The country has established a 'Local Self-Government' policy where neighborhood residents collectively govern their own health care and protection. Block associations / mass organizations, mutual support networks and locally elected committees of popular power collaborate with the Ministry of Public Health and polyclinics to manage and monitor regular health activities. This model allows citizens to protect and maximize their own health through local self-government with minimal external control (Demetrius S. Iatridis, 1999: 32). The mass associations include the Federation of Cuban Women. Elected by residents of blocks, the local leaders of these organizations reside in the neighborhoods and have close relations with the neighbors and local community conditions. Mass organizations collaborate with each other to form a broader vehicle for participation, and neighborhood blocks became the arena for residents to participate directly to improve family life, social interaction and collaboration among residents and community institutions (Demetrius S. Iatridis, 1999: 32).

However, advocates to community participation in health argued that nearly two decades after the Alma Ata Declaration the strategy and attempt that could bring 'Health For All by Year 2000' has still not been materialized. The concept of community participation in health could have success in some countries, but it has proven to be a complex process. The concept of community participation in health has been the subject of many controversies and debates since its formulation, and it is still the subject of numerous studies and research by development analysts to implement this concept and assure its success. These advocates for community participation in health also argued that the World Bank (WB) and the International Monetary Fund (IMF) with their neo-liberal economic policies across the world have a negative impact on public health. The formulation of the IMF on policies and programs in the health sector in developing countries, the socioeconomic conditions and cultural influences of these countries in community participation are among others, important factors that have contributed so far to the failure of community participation in health in the developing world, and therefore, have jeopardized the objective set at the Alma Ata Conference, which was 'Health For All by Year 2000' (Morgan, 2001: 221).

Amit Sen Gu in his article *People's Democracy*, stated that for the last two decades the infamous Structural Adjustment Policies imposed on developing countries by the IMF have decimated health care facilities in most of these countries (Sen Gu, 2002: 1). He enumerated the impact of these policies have on the health sector in developing countries:

- The gradual dismantling of the public health services due to the cut in the welfare investment.

- The introduction of service charges in public institutions, which has made the services inaccessible to the poor.

- Handing over the responsibility of health service to the private sector, which focused only on curative care, and undermining the rationality of public health.

- The voluntary sector, which has also stepped in to provide health services is forced to concentrate and prioritize only the areas where international aid is made available – like AIDS, population control, etc.

Sen Gu also explained that these policies were drastically focused upon in 1987 by the World Bank document titled "Financing Health Services in Developing Countries", document which recommended that developing countries should:

- Increase amounts paid by patients

- Develop private health insurance mechanisms, which requires dismantling of state supported health services

- Expand the participation of the private sector

- Decentralize government health care services, which is in reality not a real decentralization, but a euphemism for 'rolling back' of the responsibility and passing of the burden to local communities.

These policies were 'fine-tuned' and reiterated by the Bank's World Development Report, 1993[5], which consequently had a devastating effect on the health care services of all developing countries that have implemented the Bank's policies. For instance, the Philippines' health expenditure fell from 3.45

[5]A minimum package of public health and clinical interventions which are highly cost-effective and deal with major sources of disease burden could be provided in low income countries for about $12 per person per year, and in middle income countries for about $22. The cost would exceed what governments now spend on health in the poorest countries but would be easily affordable in middle-income countries. Governments should assure that poor populations have access to these services. Additional public expenditure should go either to extending coverage to the non-poor or to expansion beyond the minimum collection of services to an essential national package of health care including less cost effective interventions against a larger number of diseases and conditions. The World Bank's 1993 World Development Report: Investing in Health applies criteria to the design of a national package of essential health services (World Bank 1993). Because epidemiological profiles differ among countries, even at the same income level, the national package must be tailored to a country's circumstances. Collect various health services into a 'package' means that governments could proceed to either pay for or guarantee to provide any of a list of services without considering relations between one intervention and another; or they could choose not to specify outputs at all, and agree to pay for, or provide a particular collection on inputs: medical profession would decide which services were actually provides, whether by delivering services they thought justified, or by responding to patients' demand. The second approach is incompatible with maximizing value for money or getting the most health gain per dollar spent, because people often demand services offering little health improvements and do not always seek those which cost less or provide greater health gain. The first approach – choosing interventions but not packaging them – takes no account of joint cost or co-morbidity, so interventions chosen in this way will cost more than they should or reach fewer people (Jose-Luis Bobadilla, Peter Cowley, Philipp Musgrove, Helen Saxenian, *The World Bank Group*, "Design, Content and Financing of an Essential National Package of Health Services, 1995). www.worldbank.org/html/extdr/hnp/health/hlt_svcs/pack1.htm

percent of GDP in 1985 to 2 percent in 1993. Developing countries with a strong tradition of providing a comprehensive welfare benefits to its people were not spared from the changes, at the exception of Cuba (Sen Gu, 2002: 2). China's health expenditure has been reported to fall to 1 percent of GDP. In Vietnam the number of villages with clinics and maternity centers fell from 93.1 percent to 75 percent since these imposed policies by the IMF (Sen Gu, 2002: 2). In Haiti, the impact of Structural Adjustment Policies forced the government to cutback on social programs such as health care, which has hampered people's health mostly in the rural areas. In order to meet the IMF requirements, the government has also eliminated subsidies on gasoline prices. Therefore, the price of gas doubled, transportation cost shot up 60% and the cost of living skyrocketed (Haiti Action Committee, March 2004).

The *Canadian Journal of Sociology* (CJS) addresses feminist critics on SAP and the World Bank policies on gender development (*CJS,* 30 (1), 2005). These critics mainly stated that the World Bank new policies have created gender inequalities. According to the recent feminist critique, "The key to reducing gender inequalities in less developed countries lies in identifying and eliminating the male biases of the economic models underlying SAPs" (quoting Elson, 1995; Pearson, 2000). They continue by stating that the World Bank in its gender development policies have ignored the rigidities in the gender division of labor, both in paid workforce and in the household. In less developed societies, women and men tend to perform different work role. Some types of work are considered for women and others for men. This kind of division in the work role

makes it more difficult for women to enter the paid labor force, move from subsistence to commodity production, and switch to exportable production (Elson, 1995; Pearson, 2000).

Cornia et al. (1987) wrote that UNICEF researchers have noted the negative impact of SAP on women and children in less developed countries. In their research they stated that in these countries, women are burden with reproductive and domestic work, including buying and preparing food; ensuring good health and education for their children. Thus, with the privatization of government services, basic food subsidies are eliminated, user fees are applied in health services and for education, therefore, Structural Adjustment Program falls disproportionately on women and their children. To remedy this negative impact, UNICEF has called for safety nets that would protect mothers and their children from the harshness of the market, which means giving free basic health services, free literacy programmes, etc. (citing Cornia, Jolly and Stewart, 1987).

Ann Whitehead criticized the World Bank's Poverty Reduction Strategy Papers (PRSPs) on indebted countries by examining the process that the government of Bolivia, Malawi, Tanzania and Yemen adopted in their Poverty Reduction Strategy Paper. She argued that while the World Bank insisted on broad-based citizen participation in PRSP formulation, few or no women's advocacy group were consulted in the adoption of these countries' PRSP. Narrow citizen participation in PRSP formulation, as she noticed, was accompanied by weak analysis of the social roots of poverty, specially the disadvantaged position of women. There are other critical points on which she

elaborated. First, even when women and other civil society organization was consulted by government officials, their views were seldom reflected in the PRSPs. Second, The World Bank in its new PRSP policy did little to improve the position of women in less developed countries, and third, the Bank's gender development policies has failed to acknowledge the religious and political sources of local government's resistance to gender equality. Therefore, by overlooking these issues on their policies, the gender role and the material well-being of women are eroded. As she describes it: " the treatment of gender issues in the policy priority and budget commitment sections of PRSPs is fragmented and arbitrary" (CJS, 2005, quoting Whitehead, 2003: 4).

CHAPTER 3

OVERVIEW OF HAITI'S SOCIAL STRUCTURE, POLITICS AND DEMOGRAPHIC AND SOCIOECONOMIC CONDITIONS

Haiti has a land area of 27,750 sq km, about 11,000 square miles. It is a densely populated country with a population of 8.4 million (UN, 2006) and the poorest in the Western Hemisphere. Once, this nation was not as unfortunate as she is today. At one time this French Colony of Saint Domingue was the richest colony in the world. The plantations manned by slaves brought more wealth than the British colonies of North America or the Spanish colonies in the Americas combined (Alex Stepick, 1982).

After the extinction of the aboriginal population, the "Aramak and the Caraibe" in the beginning of the 17th Century, Saint Domingue (Present day, Haiti) before the independence was entirely dominated and governed by the French Colonists (lcweb2.loc.gov). The major planters and government officials who constituted the ruling class carefully controlled every segment of the population, specially the majority of African slaves and their descendants. Society at that time was structured for the production of wealth for the planters and their investor in France (lcweb2.loc.gov). During that colonial period, the French imposed a "three-tiered" social structure. At the top of the social and political ladder was the white elite. At the bottom of the social structure were the blacks slaves transported from Africa. Between the white elite and the slaves was the third group: the freedman, called "Affranchis". They came from the union

of slave-owners and slaves. Some mulatto freedman inherited land and became relatively wealthy. They also owned slaves. However, racial codes kept the "Affranchis" socially and politically inferior to the whites. Thus, the population of Saint Domingue in 1791 was made of 87% of slaves, 8% of whites and 5% of freedman. Many slaves died because of the harsh living and working conditions, and new slaves were imported from Africa to replace those who died (lcweb2.loc.gov).

As the society grew, it became strongly stratified into Frenchmen, Mulatto Freedman and Slaves. There were rivalries among the Mulattos, the French descended and the Blacks. But certain section of the colonial society took the principles of the French Revolution to heart and despite a brief period of English occupation in 1793 during the Napoleon wars, the slaves of Saint Domingue freed themselves both from their masters and from the "dependence" of France. The free republic of Haiti was proclaimed on January 1, 1804. It was the first colony in Latin America to sever its ties with the Old World, and the first black republic to achieve a successful slave rebellion in the world, also the first one to be completely independent. It was also the only place where slavery had been abolished (Stepick, 1982).

The Haitian Revolution of 1804 changed the social structure and the political tradition of the country. The colonial ruling class and most of the white population was eliminated. The plantation system was also destroyed. The country was ruled alternatively by blacks or by mulattos (lcweb2.loc.gov). The leaders tried to restore the plantation system, which relied on free labor force and

controlled by a strict military regime. But the system collapsed. After the Haitian Revolution, the leaders divided the plantations and distributed land among the former slaves. Through this process, the new Haitian upper class composed of wealthy, educated French speaking mulattos lost control over agricultural land and labour, which had been the economic basis of colonial control (lcweb2.loc.gov). To maintain their superiority and social position, the new upper class turned away from agriculture and favored a more urban-based activities, which are mostly governmental. Therefore, they became the urban elite group (lcweb2.loc.gov).

Besides these urban elite groups, were the military groups composed of disadvantaged black Haitians. In a shifting and often uneasy elite alliance with the military, the urban elite ruled the country and kept the peasantry isolated from national affairs. The urban elite promotes French norms and models in order to separate themselves from the peasantry. They shared very little with the mostly black peasants, and they differed in wealth, occupation, location, education, language, religion, family organization and culture. They disdained manual labour, industry and commerce in favor of law and medicine (lcweb2.loc.gov).

Hence, Haiti's peasantry constituted approximately 75% of the total population. Most of Haiti's peasants had owned land since the early nineteenth century (lcweb2.loc.gov). Land was the most valuable rural commodity and peasant families went to great length to retain it and increase their holdings (lcweb2.loc.gov). Peasants had control over their land-holdings, but many of them lacked clear title. Many families have passed on land over generations

without updating land titles. Heirs occasionally survey land before taking possession, but most of the time they divided the plot among themselves in presence of community witnesses and a notary. Sometimes families sold their land to raise cash for occasions like funerals or to pay for the expenses of emigration in urban areas. Peasants maintained a strong identity as cultivators of the land, but showed a weak sense of class's consciousness. Rivalries among peasants happened more often than a common resentment toward the upper class or elite (lcweb2.loc.gov).

However, over the years some civic action groups among peasants had emerged. After the 1960s, wealthy peasants led rural community councils. These councils were more to control the flow of development resources than to represent the local population (lcweb2.loc.gov). But in the 1980s, a countervailing movement of small peasant groups called "Groupman" emerged with the support of the Roman Catholic Church. These "Groupman" of common interests, i.e. the issue of land, confronted the government with regard to fair wages for their agricultural products and the recognition of their clear title of the land. They had also undertaken some cooperative activities such as, the organization of the agrarian system. Unfortunately, the Duvalier's government and the succeeding National Council of Government curbed this peasant movement (lcweb2.loc.gov). Also in the 80's, the Haitian peasantry gradually became much less isolated and excluded from national affairs. Foreign religious missionaries in the rural areas and the involvement of international development agencies have facilitated the peasants' inclusion in the nation (lcweb2.loc.gov).

No government in the history of the country (from 1804 to 1986) has ever done something of significance to improve the life of ordinary people or have left any economic stability, which could allow productive investment and economic growth in the country (Lundahl, 1998: 7). The Haitian economy is a politicized one. Politics take precedence over economics in the allocation of resources (Lundahl, 1998: 9). Politics play also a major role in decision-making at all level of government. Most government's decision on national issues has, in most part been dictated by the ruling cliques. This behavioral tradition has been detrimental to the country's growth and development. A selfish interest among politicians to enrich themselves without any concerns for the economy or for the population has produced macro-economic disequilibria (Lundahl, 9).

Haiti had its share of ruling dictators and political repression. The most notorious was Francois Duvalier, where some 30,000 - 60,000 Haitians were killed for political reasons during his 14 years in power (quoted in Ferguson, 1987: 7). Four coups d'états happened since the exile of his son Jean-Claude Duvalier, with the most recent one, which ousted President Jean-Bertrand Aristide and sent him into exile from 1991 to 1994 (Grafton and Rowlands, 1996,: 266). Soon after this latest coup the Organization of American States (OAS) enacted an economic embargo in the country with the intention of destabilizing the military regime (Bowie and Potocky, 1998: 79). This embargo had a devastating impact on the economy and mostly on people's life and health. A total of 29,780 jobs in the country's garment, electronic, sports and toy assembly industries were lost in 1991 (Gibbons & Richard, 1999: 2). By January 1994 only

44 factories out of 145 (in 1990) were in business, and the number of workers employed in the assembly industries declined from 44,000 in September 1991 to 8000 in May 1994. Women were the hardest hit by these cuts in the assembly industries. They constituted 80% of the assembly workers and the majority in the informal sector; one third of them were heads of household (Gibbons & Richard, 2). The cuts in these industries resulted of a quarter of a million Haitian losing their income. It has been reported that the embargo was associated with the loss of 200,000 jobs in the formal employment sector over 3 years, which affected more than a million people, 15% of the country's population (Gibbons & Richard, 2).

During that period price of imports rose tremendously. There was shortage of fuel and a gallon of gasoline costs US$10. The shortage of fuel creates delay for agriculture product to reach the capital. Even though food imports were exempted from the embargo, there was still delay in the delivery due to the lack of vessels entering Haitian ports (Gibbons & Richard, 1999: 2). In order to raise income during this period, many people had to sell their personal assets. Some relied on remittances from abroad; others engaged in contraband activities, mostly in retail sale of black-market gasoline and kerosene (Gibbons & Richard, 1999: 3). Prostitutions increased. Declining incomes forced people to reduce household expenditures; the quality and quantity of foods declined. The main staple food changed from rice to plantains and to breadfruit. The time that mothers spent at the market or searching for income reduced their time for meal preparation and for breastfeeding. The embargo induced shortage of propane

gas, which resulted in 18% increase in charcoal consumption. In a survey done in the rural Northwest of the country, families usually had two meals a day. But during the economic sanction in 70% of households, families only had one meal a day, and 17% of households were reduced to eat every other day (Gibbons & Richard, 1999: 4).

In the education sector, after the coup most schools closed for almost 6 months. In the academic year of 1992-1993, violence and gasoline embargo closed schools for an additional two months (Gibbons & Richard, 4). Increasing poverty forced rural families to resort to the traditional practice of placing their children, mostly girls to domestic service with relatives in the cities. These children called "restavek" or "stay with" are supposed to receive food, clothing and education in exchange for housework. But in reality these children never went to school and were victims of sexual and physical abuse (personal input). During the embargo the number of "restavek" have increased from 250,000 to a quarter of a million (Gibbons & Richard, 4). According to UNICEF the number of street children also doubled during this period because they were left unattended by parents who had to go out and fend for their family (Gibbons & Richard, 4).

With regard to nutrition prior to the coup and the embargo, average calorie consumption was 80% to 90% of recommended levels (Gibbons & Richard, 4). During the sanction the price of baby formula in Port-au-Prince increased 283%, which put a strand on non-breastfeeding mother to properly feed their children. Preschool children in Port-au-Prince suffered higher level of malnutrition than kids in other cities. Data from 42 health facilities across the country showed that

18% of patients younger than 5 years of age were moderately or severely malnourished in 1993. In Port-au-Prince facilities, 21% of youngsters were moderately or severely malnourished in the same year. In September 1994, the rate has risen to 24% in the same 42 health facilities across the country, and the rate in areas outside the capital had deteriorated to the level of Port-au-Prince (Gibbons & Richard, 4). According to the national 1994-1995 USAID financed Demographic and Health Survey, 7% of children younger than 5 years had acute malnutrition, compared with 3.4% in the 1990 survey. The 1994 survey also showed that 18% of mothers in the cities had protein-energy malnutrition. For women in the rural areas, the rate was 21%, which in both cases resulted in a low birth weight increased from 10% to 15% of newborns (Gibbons & Richard, 4).

Price on imports such as essential drugs, medical supplies has increased due to shortage in gasoline and transport. This increase resulted on scarcities of these products and made medicines expensive to purchase. The authors in their research reported that in 1993 penicillin and intravenous fluids cost three times the price during the embargo, and acetaminophen costs five times more (Gibbons & Richard, 1999: 5). They also reported that the shortage of kerosene and propane led to the collapse of the national "cold chain" for vaccine refrigeration. This shortage combined with the closing of many state health institutions and political constraints on providing vaccines to those remained open has led to a reduction in the complete immunization coverage for children. All of these constraints contributed to a measles epidemic from June 1991 to November 1993, many of these cases, 10% to 14% were fatal. The 1994-1995

USAID-financed Demographic and Health Survey found that between 1987 and 1994, the mortality of children 1 through 4 years of age rose from 56 per thousand to 61 per thousand. Much of the increase in mortality among children, 1 through 4 years was the result of the measles epidemic from June 1991 to November 1993 (quoted from USAID, USAID Monitoring Report 3 (12) (October 1994): 12). The health of women also deteriorated during the embargo. The rate of maternal mortality in 1994 was estimated at 450 deaths per 100,000 births, and increase of 29% over 1989. The causes were poor nutrition, lack of emergency services for high-risk pregnancies, decreased access to transportation in rural areas (Gibbons & Richard, 5).

Another devastating impact of the economic sanction reported was it cuts off the supply of spare parts for pump repairs, which created scarcities in water purification products and resulted in fuel shortages for water pumps. Therefore, drinking water output declined by 30% to 50% during the first 18 months of the crisis. The percentage of people having access to portable water in Port-au-Prince dropped from 53% in 1990 to 35% in 1994. Fecal contamination affected 14 to 17 springs that feeds the capital's water supply system (Gibbons & Richard, 1999: 5). Community water management committees played an important role in maintaining water systems. But supply problems combined with political repression reduced committees' involvement and maintenance. In the rural areas people relied mostly on commercial water truck to fill community cisterns. But high cost of fuel raised the price of water therefore, people in these areas were

forced to reduce their water consumption or drink contaminated water (Gibbons & Richard, 5).

Haiti relied greatly on external aid, 40% of its budget. But OAS, which called for the sanction did not want any relation with the de facto government. Therefore, this resolution was interpreted by the international agencies as a decision to put on hold any resources to the public sector, even to community health center or to schools (Gibbons & Richard, 1999, 6). These holds from the international aids resulted in a delay to pay government officials and a delay in services. Consequently, public employees abandoned their posts, and schools and health clinics suffered tremendously (Gibbons & Richard, 6).

"The dictatorship and the embargo transformed a poor but functioning health care delivery system into a health care delivery crisis" (Fournier, MD and Dodard, MD, 1997: 667). Prior to the arrival of the US forces during this period, there were looting and pillaging of health care facilities. There was a shift in the responsibility of the health care delivery to non-governmental organizations. But matters got complicated when assistance from the international communities became politicized (Fournier & Dodard, 668). As the authors stated, many humanitarian organizations opted not to send money unless democracy in the country was restored and "a viable political and economic infrastructure was reestablished". International funding, mostly funding from States Agency for International Development (USAID) that was directed to Haiti frequently went through various contractors with little support trickling down to Haitian health professionals for the provision of care. As rightfully stated by the authors: "Haiti

serves as a paradigm as to how social, economic and political factors influence Health" (Fournier & Dodard, p. 668).

Decade later, Haiti is still suffering form the impact of the embargo. The return of President Aristide into power in 1994 has not restored economic or political stability in the country. The economic situation was the worst the country has never experienced, with per capita income fallen to an estimated US$ 250 dollar or less (Lundaht, 1998: 11). Thirteen years after the end of the sanctions, the political and economic disorder it created, offer little hope for conditions to improve in Haiti. Due to political uncertainty some donors have withheld their economic aid in the country (Collymore, 2004: 1).

Health sector was the hardest hit by these holdings. The recent health profile shows that HIV/AIDS is the highest in the region at 5.6 per cent of the adult population (Country profile: Haiti, 2006). Maternal mortality has increased from 523 to 680 deaths per 100,000 live births, the highest in the Western Hemisphere. The cause of maternal mortality in Haiti is mostly attributed to anemia (30%), iodine deficiency (25%), eclampsia and hypertension (31%), haemorrahges (22%), infections (20%) and complications from abortion (16%) (UNICEF Report, 1999). In addition, 52 cases of neonatal tetanus were recorded in 1998, which indicated a lack of hygienic conditions and lack of sanitation during childbirth (PAHO, 1998). These findings are attributed to poor sterilization of instruments for childbirth and poor handling of emergency situation that is occurring during childbirth. Maternal mortality in Haiti is also the result of previous ill health conditions endured by impoverished women, such as malnutrition and

malaria that are exacerbated by the pregnancy or its management (WHO Press Release, 1999). Another contributing factor of this crisis is that women with low income have limited access to medical facilities or services, are unable to receive any health education and any prenatal or postnatal care, which could prevent any of the complications and death. The lack of women's education and empowerment unable them to make decisions to control and limit the number of pregnancies (WHO, 1999). Total fertility rate is 4.5 lifetime births per woman and the population growth rate is 1.4 per cent per year (Country profile: Haiti, 2006). Successive governments have tried to lower the rate through educational method by integrating sexual health education into schools, increasing access to modern contraceptive methods and by channeling the information through the media. Nevertheless, the results have been unsatisfactory (Country overview: http:// www. unfpa.org/profile/haiti.cfm).

This rapid population growth has contributed to the country's environmental degradation and the breakdown of its social order (La Jolla and Sherbinin, 1996: 1). Over 60% of the population lives in the rural areas and most of them subsist on small-scale agriculture and other resource-intensive activities. This has led to widespread environmental problems such as, deforestation and soil erosion (La Jolla & de Sherbinin: 2). 70% of the country's energy requirement is done with wood and charcoal (La Jolla & Sherbinin, cited in Hammand, 1992). Forest fragmentation is happening at a fast rate, and tree cutting has increased during the 1991-1994 economic embargo to compensate for decreased imports of fossil fuels (La Jolla & Sherbinin, cited in Tardieu, 1992). According to Tardieu,

wood cutting activities and the making of charcoal is also a source of income for many poor Haitians. Today only 1% to 3% of the land area is still in forests (cited Tardieu, 1992).

As pointed out by Gibbons and Garfield, the embargo marked its impact on the economy, especially on the rural poor, women and unskilled factory workers. By reducing health and education, it had also reduced the country's ability to participate in the global economy and to implement democracy. They also pointed out that the embargo caused enormous social dislocation, increased women's economic burden and encouraged the breakdown of Haiti's family structure (Gibbons & Garfield, 1999: 1502). The latest report from the World Bank on Haiti shows how the internal conflicts and mostly the embargo has devastated the economy of the country and has afflicted severe hardship on the population. As stated in the 2004 World Bank report:

- GDP per capita is of US$361 (2003)
- 65 percent of the population lives under the poverty line
- Life expectancy is 53 years
- Under-five mortality rate is of 123 out of 1,000
- Half of the population does not have access to clean drinking water and only 28 percent have access to decent sanitary equipment
- High incidence of HIV/AIDS (5 percent)
- 97 percent deforestation (World Bank Group, 2004: 1).

However, after the constitutional order in 1994, the government adopted an Emergency and Economic Reconstruction Program (EERP). The purpose of this program was to recover the country's economy and to improve its economic indicators in the period of 1995-1998 (World Bank Report, 2004: 2). Also following the return of President Aristide in 1994, effort was made by the government to improve the country's economy and improve health conditions for the population. In response to this effort, the Ministry of Health introduced in March 1996 a health policy that recognizes the right to health and the State's obligation to guarantee access to health care for all. A health reform was designed by the State to ensure equal access to a minimum package of health services to the population, such as: a comprehensive child care targeting acute respiratory infections, a comprehensive health care for women with emphasis on pregnancies and reduction of maternal mortality, vaccination, access to essential drugs, prevention of communicable diseases, prevention and control of malaria, strengthening health promotion activities to encourage people to take responsibility of their health and provisions for community participation (PAHO, 2001: 12-15). The Ministry of Health joined its effort with other Ministries, such as the Ministry of Education and the Ministry of Social Works to develop school health policies appropriate to Haiti and to develop a health program for workers (PAHO, 2001: 15).

Unfortunately, this initiative undertaken by the Ministry of Health and the implementation of the Emergency and Economic Reconstruction Program was short live due to the political crisis of 1997 (World Bank, 2004: 2). As stated in

the report: "Political discord, lack of commitment to reforms, weak institutions and loss of investor confidence resulted in the gradual decrease of much needed external assistance and private investment in the late 1990s and early 2000s" (World Bank, 2). Private transfers, mainly remittance from Haitians living abroad doubled from US$256 million in 1997 to US$650 million in 2002 (World Bank, 2). This remittance has partially offset the negative impact of the sanction and has helped the most needed of the population. But the stop on publicly funded social programs and the withholding of funds from donors has created a decline in the delivery of basic services, such as water and health services. Furthermore, the social and economic situation drastically deteriorated in 2002, which has flamed political and civil unrest and which has precipitated the departure of President Aristide in 2004 (World Bank, 2004: 2).

Haiti's recent economic development, as stated in the 2004 World Bank Report has regressed. The latest conflict caused severe property damage in both public and private sectors. The losses of property and closure of businesses created disruption in economic activities for weeks. This disruption resulted in chaos in the supply system. Therefore, in 2004 monthly inflation in the country increased to 6.5 percent in April of this year from 1.5 percent in February. This sharp rise of the inflation caused widespread supply constraints (e.g. closing of ports and looting of warehouses) and sharp increase in international commodity prices. Net international reserves (NIR) fell drastically low to US$17 million at the end of March of that year (World Bank, 2004: 3). There were some economic recovery again due to the remittances, but

according to the Report, the GDP was expected to decline by 5 percent that year. Insecurity and political violence paralyzed the country's day-to-day economic activities. As stated by Gibbons and Garfield (1999: 1503) in their article:

> Democracy's best hope was the determination of the Haitian people to overcome the heritage of their dictatorial past. Their call for sanctions is an indicator of that determination. Neither they nor the international community anticipated that sanctions would set back democracy by reducing economic activity and access to health and education, impoverishing the middle class, lessening the care of children, and weakening the national institutions for years after the embargo."

After the departure of President Aristide, a Transitional Government of Haiti were formed and they formed in March 2004 a partnership with donor agencies, international and regional organizations to respond to the country urgent social, economic and institutional needs (World Bank, 2004: 4). These joint groups identified four priority areas to act on urgently.

A) Improving political governance and promoting national dialogue, which includes security, police, disarmament and human rights.

B) Strengthening economic governance and promoting institutional governance, which includes strengthening regional, urban and local development and decentralization.

C) Promoting economic recovery, which includes electricity, private sector development, agriculture, road and transports, environmental protection and rehabilitation.

D) Improving access to basic services, such as health and nutrition, food security, education, water and sanitation, solid waste, safety nets and social

protection (World Bank,, 2004: 4). Bilateral and multilateral agencies, such as USAID, CIDA, the World Health and Pan American Health Organizations and a variety of private philanthropic institutions that supports NGOs have pledged to finance Haiti in its economic and social reconstruction (World Bank,2004: 4). The finance pledged by the international community for the reconstruction of Haiti still remains to be seen, and the implementation of this Transitional Government and partnership with multilevel participants is slow from showing any results. In my opinion this is mostly due to the fragile state of the country and the overwhelming development work that has to be done at all level of government's institutions.

As stated in the World Bank Document named "Haiti: Options and Opportunities for Inclusive Growth", the Haitian population has demonstrated resilience and creativity when confronting challenges. Marred by political instability, and economic mismanagement the country has suffered negative economic growth for three decades. The document has also stated that even when the country has had some economic growth it has not been sustained due to Haiti's pattern of socioeconomic development characterized by marked inequalities in access to productive assets and public services (World Bank Document, 2006, Report No. 36069-HT). The author argued that these inequalities are "the results of exclusionary policies and ineffective public institutions" (World Bank Document, 2006, No. 36069-HT). He also argued in his report that the resulting widespread poverty meant that less gains from growth, when there is growth, has been trickled down to the poor. So in return "the inability of poor Haitians to exploit growth-promoting opportunities for investment

in physical and human capital has created a vicious circle of weak economic growth and persistent poverty and inequality" (World Bank Document, 2006, Report No. 36069-HT).

CHAPTER 4

NGOS IN HAITI: TWO DECADES OF WORK

Poor social and economic development and poverty has made Haiti a prime target for international aid. International non-governmental organizations (NGOs) have been providing relief, charity and social sector services since the 1950s. However, humanitarian aids have been increasing due to decades of political unrest in the country and mostly during and after the economic sanction imposed by the UN. Multiple emergency relief and projects in the sector of health, education, nutrition and agriculture have been put in place by these NGOs in response to the crisis and to help alleviate the suffering of the poor. With maternal mortality on the rise, most NGOs have improvement of maternal health in their mandate.

The two oldest established NGO in Haiti are the run-hospital Albert Schweitzer and CARE Foundation. CARE has been working in Haiti in 1954 to provide humanitarian relief after the hurricane Haze. In 1959 it shifted its activities by focusing on maternal and children nutrition. In 1966, CARE launched a community development program in the Northwest region of the country, and in the 1970 it broadened their programming to include intervention-health to preschool children, provision of safe drinking water. In the 1980s CARE extended their programming to include agriculture and natural resources, education and

sanitation, primary health care and small projects enterprise (http://www.careinternational.org.uk/cares_work/where/haiti/reports/haiti_projects.htm).

During the embargo in 1991-1994 CARE focused on providing humanitarian feeding and rehabilitation projects. Today, CARE's work in Haiti reaches numerous regions of the country and continue extending its program in reproductive health, maternal and children's health, HIV/AIDS, food security, water and sanitation. In 2001, CARE launched the Tuberculosis Project in the Southern and Northwest regions of the country. This project is to reduce the transmission of the disease by intensifying early detection, support the minimal rehabilitation of lab infrastructure, reinforce network to ensure effective treatment, ensure regular supply of essential TB drugs and increase the capacity of local personal through training and supervision. In 2002, CARE launched the Reproductive Health and Child Survival Project in the same areas the help reduce the high rate of maternal and child mortality in these regions (www.careinternational.org.uk/cares_work/where/haiti/reports/haiti_projects.htm).

During time of crisis in the early 80s when the Government of Haiti (GOH) was unable to provide minimal social services, such as primary and curative health care, basic education, basic community water and sanitation infrastructure, numbers of NGOs stepped in to provide these services. Then since the 80s they played an integral role in assisting the country deliver social services to the people in need. (Morton, 1988: 2; Schneidman & Levine, 1996: 4). NGOs in the 1980s were in for front in the provision of health services in Haiti, in particular in the rural areas (Baer, 1999: 5). For the most part of 1987-1994 major

donor has turned to NGOs to provide basic services and safety net programs. It was estimated that $100,000 million of official development assistance was run by NGOs from 1992 to 1994 after the coup d'Etat against President Aristide (Morton, 1988: 1). During the crisis period, NGOs were the only sources of health services in many remote areas. It is estimated at that time, 60% of health services were provided by them, and it is estimated that even today they probably still providing about 50% of primary and curative health services (Morton, 1988: 3).

NGOs provide services to certain geographical regions or to targeted groups, such as women of reproductive age, children). They are involved in a wide range of activities including, hospital care, primary health care and emergency care, HIV/ AIDS and communicable diseases. Their activities also extend to water supply, rural credit and literacy (Schneidman & Levine: 4). NGOs often use community health, outreach workers and community-based organizations to disseminate their services. A great number of NGOs are consisted of international relief organizations, such as CARE, UNICEF, USAID, Save the Children and World Vision. Other NGOs are also church-based organizations such as Seventh Day Adventist, African Methodist Episcopal, Baptist, Methodist, Catholic and Mennonite church agencies (Bowie and Potocky, 1998: 84). The list "Des Organisations Non-Gouvernementales (Haitian Ministry of Planning, 1994) indicated that 291 health and human service programs existed in the country as of March 1994. Most of these NGOs operated in education (33%) and health (30%) programs, followed by community development (11.7%)

and social assistance (11.3%) (Bowie & Potocky, 1998: 84). The NGOs' sources of funding varied, but most funding are provided by USAID, United Nations agencies, CIDA, the Haitian Health Ministry and private donors, such as religious charity organizations, Bill and Melinda Gates' foundation, just to name a few (Bowie & Potocky, 1998: 87).

The past decade has been another testing period for the public sector in Haiti and the health sector has been the hardest hit. Growing financial burden and shrinking of resource of the public sector has shifted service deliveries to the private sector, mostly to the NGOs. Many NGOs' health facilities were established in the last decade to respond to the deterioration of the public system. At the present, approximately 40% of health facilities are operated and financed by NGOs, and another 25% of health facilities have a mixed management – management by NGOs and personnel issued from the public sector (Baer, 1999: 5-6). In the rural areas, seven out of ten health facilities are ran by private or mixed management (Baer, p. 5). While the NGOs gained great influence in the country during the last decade, their activities have taken place outside of the sectoral planning process (Baer, 6). The World Bank NGO study, *Background for 1997 Poverty Assessment,* found that in a sample of 24 NGOs active in health and population activities, the number of personnel in these organizations ranged from 8 to 402 employees and their funding sources ranged from international charity to international bilateral aid agencies to local charities with religious affiliations. This study also stated that the government's efforts to regulate this independent group of NGOs have been unsuccessful.

As part of a study conducted by Bowie and Potocky on the resource assessment of social service and health organizations in Haiti, 18 NGOs that provided a range of preventive and intervention health services were used as case study. The project objectives of these NGOs were to provide environmental hygiene, such as clean water, education, nutrition, family planning, prenatal care, STD/AIDS prevention and health education designed to promote early treatment instead of seeking treatment from traditional healers (Bowie & Potocky, 84). But according to the authors' report, most of these NGOs' service deliveries were to respond to ongoing crisis situations and immediate needs. As they stated: "NGO resources were always being pushed to the limit by the sheer magnitude and the nature of the political, social and economic stressors in Haiti, which makes it difficult to implement their objectives (Bowie & Potocky, 85). In their study they reported the various challenges encounter by the NGOs. The most prevalent one was the NGOs' unmet objectives due to the inability their inability to recruit adequate staff, lack of material supplies and medical equipment, poor transportation and service accessibility and poor communications equipment (Bowie et al., 88). Therefore, their recommendations with report to this study, is that multilevel intervention strategies are needed to address the issue of poverty in Haiti. In addition, they recommended that the Haitian government should establish cooperative relationship with the business community to foster philanthropic tradition through financial incentives for charitable contributions. Also they recommended that the government should revitalize9 training programs for health and social service practitioners. Finally, indigenous NGOs

should be strengthened and expanded through the provision of technical assistance, and the indigenous NGOs organizational capacity should be in par with the international NGOs because as the authors discovered in their study, the international organizations were far more sophisticated in term of technology, service deliveries, administrative services and in term of programs and fiscal monitoring (Bowie & Potocky, 1998: 89).

Franklin C. Baer's study on NGOs and women's health services in Haiti in 1999, examined the work of three NGOs in Haiti: MARCH (Management And Resources for Community Health), ICC (International Child Care) and ProFamil (Association for the Promotion of the Haitian Family). All three NGOs focused on the delivery of women's health services.

1) MARCH is a Haitian NGO, which started in 1985 to respond to more basic concerns of the population in the area of health and community development. As stated by the author: **"**MARCH is an excellent example of Korten's four development strategies because it is a national NGO, which began with an emphasis on community development (Baer, p. 8)**"**. Their objectives are to offer comprehensive health services as well as agricultural extension, community organization and rural credit. MARCH also focuses on community empowerment for sustained development (Baer, 1999: 8). MARCH owns and operates health facilities (hospital and dispensaries), which puts him at an advantage over other international NGOs, such as Save the Children, which does not have these facilities. MARCH self-dependence is a key factor on its

relationship and partnership with Haiti MSPP (Ministère de la Santé Publique et de la Population). MARCH serves a population of about 125, 000 people situated in the district of Mirebalais and Saut d'Eau in the Central Highlands. But it also deserves other areas in Port-au-Prince and its surroundings. Its dispensaries are staffed by government personnel, which each partner (MARCH and MSPP) sharing 50% of salary cost. MARCH provides in its facilities: preventive care, prenatal care, emergency deliveries and curative care. Its activities include also community-based services and women's group activities (Baer, 10). Their health services are brought to villagers using the "health station rally post" model, originally developed by Hospital Albert Schweitzer, established in Haiti since 1950. MARCH is addressing in its health programs issues pointed out in the "Three Delays", but failed to properly address issues related to travel time to health facilities, transportation and cost. However, they looked at community-based transportation systems, which involved coupling two bicycles or a motorcycle with a side car; they also setup a radio network between hospital and dispensaries to facilitate communications for long-distance emergency care and transportation requests. The World Health Organization financed this system. Unfortunately, when the term of the contract expired, so did the maintenance on the system (Baer, 1999, 11).

2) International Child Care (ICC) is a non-denominational Christian health development agency, whose mission and expertise focus on issues of maternal and childcare, community-based primary health care and tuberculosis control (Baer, 1999, p. 16). Since 1967, ICC's work in the health sector, mostly in north

region of the country has been remarkable. Their priorities in health projects are to:

- Promote sustainable national health systems
- Improve women's health, including their reproductive health
- Improve the health of children
- Decrease malnutrition and eliminate micronutrient deficiencies
- Control important and emerging pandemics, such as tuberculosis
- Introduce appropriate technologies and special initiatives (Baer, 1999, 16).

ICC developed an *Integrated Community Health Project*, which targeted a population of 59,000 people living in the rural areas of Grande Rivière and Bahon, situate in the northern region of the country. The project goal is to improve the overall health of the targeted population, in particular the health of women and children by increasing access to effective and affordable primary health care services and by establishing sustainable mechanisms at the community level to increase awareness on health issues (Baer, 1999: 18). This project provided as well reproductive health education to over 16,000 women in these regions, and it encouraged girls to wait as long as they can before having children (www.intlchildcare.org - winter 2003). Hence, ICC's community health interventions include: child health, maternal health protection and promotion, health education, basic diagnosis and treatment of common illness. ICC's project provided as well resources at the community level, such as the Minimum Package of Services of the MSPP at the exception of dental care and surgical

emergencies, water and sanitation (Baer, 19). ICC does not own and operate any health facilities within its project areas. This factor influences its relationship with the MSPP (Baer, 17).

3) The Association for the Promotion of the Haitian Family (ProFamil) was created in 1984 in affiliation with the International Planned Parenthood Federation (Baer, 1999, 26). This NGO provides more specialized facility-based health services and lesser community-based services via mobile teams for health education and consultations. ProFamil is a national NGO and works in partnership with the government and other public and private institutions. Their mission is to: promote reproductive health; promote sex and life education for families and youth; increase status of Haitian women; and work against maternal mortality (Baer, 26). Like MARCH and ICC, ProFamil applies the Three Delays model for maternal mortality. But like the two others, they are not addressing the issue of transportation related delays, such as "travel time to health facility" and "transportation and cost" (Baer, 1999: 28). Their current programs and projects include family planning and prenatal clinics, and they are mostly known for their work in women's health and reproductive health services. They provide health services to a population of almost 800,000 people in four geographic areas of Port-au-Prince, Port- de-Paix, Anse-Rouge and Jacmel (South-East Department) (Baer, 27).

All three NGOs, MARCH, ICC and ProFamil offer women's health services and are using facility-based and community-based health development strategies. Furthermore, MARCH and ICC is more active in sustainable systems

development and in people's movement via self-selected women's groups. The two national NGOs, MARCH and ProFamil are in advantage over ICC, the international Christian based NGOs, because they owned health facilities and partner with the Ministry of Health facilitate, which facilitate the delivery of their services. However, ICC has contributed tremendously in the delivery of health services for the most needed population and their health programs have contributed as well to the improvement of women health, mostly in the rural areas of the country.

Haiti has seen an influx of NGOs after 1994. Many of them were church-based NGOs, philanthropists and expatriates' NGOs. All brought relief in the sector education, water and sanitation but mostly in the sector of health. To mention a few: *Haiti Outreach – Pwoje Espwa (H.O.P.E.)* is a not-for-profit, volunteer organization based in Rochester, NY, which has been in Haiti since 1995. The organization's primary goal is to promote grassroots development in the Commune of Borgne, the northern part of Haiti by providing technical, educational and financial support in the areas of health, education and economic development, as well as addressing the issue of infant and maternal health through a perinatal project (http://haitimedical.com/hope). H.O.P.E. 2001-2005 Child Survival project aims to improve both health services and case management by auxiliaries in clinics, community practices through outreach promoters, women's and men's clubs, community-based distribution of contraceptives and breastfeeding support groups (http://www.childsurvival.com/projects/projectDetail.cfm?proj_ID=426). *Partners In Health* is a small

community health project started by Dr. Paul Farmer and his Haitian colleagues in early 1980s in Cange, in Haiti's Central Plateau. Today its sister organization, "Zanmi Lasante" (Friends of Health) operates a full service medical center in the area and, in partnership with the Ministry of Health has extended its center to seven additional sites across the Central region of the country (http://www.pih org/wherewework/haiti/index.html).

In 1998, they launched, against the advice of global health experts, the HIV Equity Initiative to provide free antiretroviral therapy to AIDS patients using a community-based model that trains and employs local Haitians to administer daily medications and provide social support to those affected. The HIV Equity Initiative helps start the formation of the Global Fund to Fight AIDS, Tuberculosis and Malaria. This Initiative is now a global model for the delivery of community-based treatment for complex diseases within the context of comprehensive primary care (www.pih.org/wherewework/haiti/index.html).

As of July 2005, Partners In Health and its sister organization Zanmi Lasante are the only provider of a comprehensive primary care for the impoverished rural population that they are serving, 912,000 patients recorded in 2004 across Zanmi Lasante's clinical sites and at mobile outreach clinics. Both partners are the pioneers' model for AIDS treatment and for the provision of the antiretroviral therapy, and pioneer in extensive prevention and education program (www.pih.org/wherewework/haiti/index.html). By partnering with a local NGO and with the Ministry of Health, Partners In Health was able to obtain the involvement of the community and to maintain the sustainability of its project.

Global Health Action (GHA) is a non-profit Atlanta-based health education and leadership training organization, which is affiliated with the Methodist Church. This organization has initiated the Healthy Mothers, the Healthy Children Program in the region of Petit-Goave, Southern part of Haiti and in the Island of La Gonave, Haiti to address the issue of high maternal mortality rate (http://www.globalhealthaction.org/childsurvivalprojectusaid.html). Their objective is to provide prenatal and postnatal care, adequate management of deliveries, sexually transmitted disease prevention and treatment, and child spacing. Their program activities also consist on training the community health worker in basic health and community development, in health teaching skills and in problem solving (http://www.globalhealthaction.org/chw.html).

Medecins Sans Frontieres (MSF) or Doctors Without Borders has been in Haiti since 1994 and has provided health care services to many impoverished Haitian in various regions of the country. Many of their projects focus on reproductive and maternal health to improve care in this area (http://www.msf. org/countries/index.cfm?).

McMaster University's Women's Health Initiative in Haiti with a vision to reduce maternal mortality associated with pregnancy and delivery. Their project's objectives was to increase the capacity of the Faculty of Medicine of State University of Haiti by developing a curriculum to enhance the skills of physicians in meeting the needs of women in reproductive health. To increase the capacity of Haiti's School of Nursing by enhancing the skills of graduate nurses in meeting the needs of women in reproductive health, and to reopen an effective training

program for midwives in Haiti. Their last objective was to increase access by women at the community level to information on modern methods of family planning and to increase the overall percentage of sexually active couples who are practicing some form of birth spacing (Copy of Draft Project Proposal, Haiti: A Women's Health Initiative, 2000, p. 3 / CIDA and McMaster University Help Reduce Maternal Mortality in Haiti, http://www.acdi-cida.gc.ca/cida_ind.nsf/8...).

Major bilateral and multilateral donor agencies have made available multiple funding resources to address the issue of maternal mortality in Haiti. International NGOs have received and utilized these funding to initiate various health projects and programs to improve women health in order to reduce the rate of maternal death in the country. However, despite all these health initiatives for women by the international NGOs and church-based organizations, the rate of maternal mortality in Haiti has not shown any sign of improvement, and according to the recent UN Report on Haiti, the rate has increased. Kathambi Kinoti in her recent article entitled '*Aid Effectiveness: Women's rights concerns*' attributed the failure of any development projects or health projects to the lack of women's empowerment and to the way bilateral an multilateral donors distribute their funding toward development aid. According to the author, development aid often fails to achieve its intended results and fails to reach the best results for the targeted beneficiaries (AWID Friday File, August 10, 2007). As she explained, the recognition of gender equality has yet to be translated to adequate allocation of money to bridging gender inequalities. Furthermore, she explained that the

concept of gender mainstreaming has lost its meaning in the development process and women's empowerment, which is an important aspect of gender equality has been overlooked (Kahambi, 2007). She also stated: "Women's empowerment is not placed at the heart of development efforts, and aid cannot be effective if funding for women's empowerment is inadequate".

The second point that the author explained to be the cause of failure of development aid and development projects in underdeveloped countries is that there is a lack of transparency and accountability on the part of bilateral and multilateral donors. These donors often give aid with political strings attach, such as strategy in the acquisition of resources by the country they are providing aid, its security agenda, the ideological concerns of its policymakers. Therefore, the direction of development initiatives is determined in most part by the donor without any consideration of the recipients' needs (Kathambi, 2007). For instance, the "global gag" as she explained puts restriction on the type of information and services that recipient of the US aid can obtain with regard to sexual and reproductive rights and health. This rule impedes women's access to adequate information, which as a result compromises the health and well-being of many women in the Global South (Kathambi, 2007). Hence, Haiti being a primary recipient of US aid is most likely to be subject to the "global gag rule" and to these various political strings attach imposed by donors.

The other cause of failure of development project explained by the author in her article is that aid effectiveness is often hampered by donors' cumbersome, overly technical and sometimes irrelevant approaches to measure impacts and

outcomes. As she stated: "The pre-set indicators are not responsive to the complex social, political and economic dynamics of the aid recipients' contexts". Finally she argued that aid ineffectiveness is also attributed to the recipient country's poor governance, corruption and inefficacity (Kathambi, 2007).

CHAPTER 5

REPORT ON FIELD RESEARCH IN LÉÔGANE, HAITI

I chose Léôgane for my field research because it is close to Port-au-Prince, thus easy access to the airport and easy to travel to the capital to meet with government officials and obtain government documents. Also for safety reason, it is a very calm and secure area. The other raison for choosing the town of Léôgane is because of its hospital. Sainte Croix hospital has a good reputation in the country and has significantly cooperated in public health research in the region.

Prior to my departure I contacted Dr. Dayane Beau de Rochars, one of the medical staff in the hospital who was my contact person, and to whom I submitted a request to be hosted by Sainte Croix hospital to conduct a field study in Léôgane on programs and services offered to pregnant women in the region to tackle the issue of maternal mortality. She was also the person with whom I made necessary arrangements for the airport and for my accommodation at the hospital residence. I sent her my objective for this study and a tentative schedule for various meetings and for site visits. She arranged the scheduling of meetings with the hospital's administrators, meetings with the medical staff and the arrangement for site visits.

5.1 About Léôgane and Hôpital Sainte Croix

The commune of Léôgane, with a population of 179,718 inhabitants is an extensive rural area located about thirty kilometers west of Port-au-Prince. It has high mountains, a broad alluvial plain devoted largely to sugar cane production and coastal fishing communities on the Bay of Gônave. The town of Léôgane is the market center for the region (http://members.aol.com/donibess/hphsc.htm). It is a very calm and pleasant region, which attracts a lot of people escaping from the violence and kidnapping in Port-au-Prince.

Hôpital Sainte Croix (Holy Cross Hospital) is a private institution located in the center of the town of Léôgane. It started as a small aid station by a Haitian Episcopal priest in the late 60s. It now fills a five-acre urban compound. It is owned by the Episcopal Church of Haiti, and operates with partnership support from the Presbyterian Church (USA). It also receives support from Children's Medical Missions of Haiti (an Episcopal endowment), the Medical Benevolence Foundation (Presbyterian), and other church-related and private sources. The hospital receives special project support from several international agencies (http://members.aol.com/donibess/hphsc.htm). The years 1983-1984 saw the expansion of six nearby rural rally posts (mobile clinics) into a regional health program serving remote mountain villages as well as sites in the nearby coastal plain. In January 1985, the Ministry of Health designated the hospital as the official health authority for the Léôgane commune, with the Medical Director being also the Director of the Sanitary Sub-District of Léôgane. However, the

Medical Director of the hospital reports directly to the Bishop of Haiti. In 1995, the Bishop appointed the first Haitian medical director, Dr. Jack Guy Lafontant, who made the entire staff of the hospital Haitian (http://www.emmf.com/hscroix.htm).

The hospital has grown to a 120-bed institution, and offers comprehensive in-patient and outpatient services for the poor. Facilities include four operating rooms, two delivery rooms, a dental clinic, laboratory services and a 24 hours emergency room. A midwifery education program trains and supervised midwives to serve in the rural areas surrounding Léôgane. An extensive community health program provides backup support to over 100 village health workers whom the hospital has trained and who work in thirteen clinics, some of which are accessible only by walking (*International Health Ministries Office,* http://www.pcusa.org/health/international/profiles/hsc/htm).

Hôpital Sainte Croix operates a Community Medical Center at nearby Darbonne, which since 1982 has trained more than nine hundred health workers for Léôgane and Haiti. As of February 1996, there are 123 health workers and 200 trained midwives serving in the Léôgane region. The Community Medical Center coordinates and re-supplies this network, which serves parish and village clinics throughout the immediate rural region (http://members.aol.com/donibess/hphsc.htm). Sainte Croix hospital supervises also the dispensary of Beauséjour, a private institution totally under its administration. The dispensary is situated in the mountains at a 7 hours walk from Sainte Croix hospital. There is one medical auxiliary working there and offering general consultation.

The hospital also cooperates with the Centers for Disease Control in significant public health research in the region, including ongoing studies in dengue fever and Lymphatic Filariasis (Elephantiasis) where screening and treatment clinics is offered in four outlying communities (http://members.aol.com/donibess/hphsc.htm).

Hôpital Sainte Croix invites volunteer physicians, dentists and other health professionals from abroad. Medical visitors assist in specialty care, consult with Haitian medical staff, hold continuing medical education conferences, and support and encourage the hospital staff as it seeks to develop a high standard of medical for this most needy nation. Specialists have played key roles in the development of hospital services. However, visiting family physicians willing to go out into the villages with interpreters and Haitian physicians to hold clinics, screen patients and refer them to the hospital. This is very important to the hospital program, for they encourage and support the work of local physicians and the work of the community health workers. Medical visitors come sometimes as individuals or in teams to support the work of local physicians and of the community health workers. Other non-medical visitor teams provides also important help in various projects, such as electrical and computer services (http://members.aol.com/donibess/hphsc.htm).

However, Sainte Croix hospital faces daily challenges in the management of its programs and services. The hospital carries out its mission in a facility that lacks adequate surgical and laboratory equipment, and struggles daily with falling electricity and plumbing systems. Presbyterians from many U.S. congregations

regularly provide both medical mission teams to the Léôgane area and assistance with repairs and maintenance to the hospital facilities. But the forces of a weakening national economy and political instability have compounded the challenges facing the hospital's staff and its dedicated supporters in the U.S. (International Health Ministries Office: http://www.pcusa.org/health/international/profiles/hsc.htm).

Health conditions in Léôgane mirror the poverty and disease that afflicts all of Haiti. Life expectancy in the region is only 42 years. Inadequate nutrition and poor sanitation contribute to illness, malnutrition and skin diseases. Respiratory infections are common in children, and infant mortality rates are extremely high. Among adults, HIV/AIDS continues to be a critical health issue and malaria is a chronic health problem in the outlying areas.

In the Léôgane region there are around 33,171 women and 4% of them are pregnant. Women living in the surrounding and mountainous regions of Léôgane are still giving birth at home and sometimes in the most unsanitary and rudimentary manner. The causes of maternal mortality in Léôgane and its surroundings are the same as the national report on the causes of maternal deaths, which are: eclampsia, anemia, hemorrhaging and infection. The cases of anemia among pregnant women in the region of Léôgane are particularly alarming due the prevalence of malaria in the region.

5.2 Field research Report

I stayed in the hospital grounds during all the period of my study. I was very comfortable in my surrounding and the residence staff was very friendly and cooperative. The staff from the hospital residence spoke only Creole and the administrative staff and the doctors spoke both French and Creole. Being born and raised in Haiti I speak the two languages fluently therefore, it was easy to converse with all the people on the field.

The day after my arrival in Léôgane, I had a meeting in the hospital with the General Director, the Financial and Administrative Consultant and the Coordinator/Community Doctor of the "Centre Maternel Communautaire" of Darbonne. The structure of the meeting was informal. Semi-structure questions formulated in a conversational style. The three staff members present were very cordial and very cooperative. However, before the meeting started, the General Director of the hospital kindly requested that the name of the three people present remained anonymous. Therefore, in my transcript I will only use the people's title. In the meeting the Director willingly answered my questions about the various programs and services the hospital offer to the community, but he quickly turned to the Community Doctor to answer the more specific questions that I asked with regard to the causes of maternal mortality in the region and the remedies used by the medical staff and the health agents to address this problem. Therefore, most of my questions were directly addressed to the

community doctor. The interview at the meeting was conducted in French, and I have translated the transcript for the thesis.

Q. What type of health programs the hospital offers to mother and child in Léôgane and its surroundings?

A. (Director): We have health stations in all 13 sections of Léôgane, where we offer monthly consultation to women and children. These health stations are placed in Darbonne, Grande-Rivière and Petite-Rivière, in Beauséjour, in Trouin, just to name a few. We have the "Centre Maternel Communautaire situated in Darbonne where we offer training to midwives and health agents to assist mothers during labour. We also train the local nurses on how to train the midwives and the health agents and also on how to supervise their work. The training received by the midwives and health agents will allow them to give to the traditional birth attendants some training on sanitation, how to sterilize the instruments they use during the delivery. Their training will help them teach the traditional birth attendants on how to detect women at risks during labor and when to refer them to the hospital. – The practice for pregnant women living in the remote mountainous areas is that when they are in labor the traditional birth attendants in their area perform the delivery. These women trust them. So it is important that traditional birth attendants receive some sort of training. – I have to mention that there are 265 midwives for the 13 sections in Léôgane.

Q. How do you go to offer these services to the population?

A. (Director): We have health agents available in all these 13 sections and their functions are to do the first examination for the infants. It includes the administration of vaccines to infants, weighing the infants and to distribute Vitamin A, Iodine tablets to children. They also educate mothers on how to take care of their infants. The theme for the education varies in each visit. For instance, the theme can be on how to introduce the oral serum in case the baby has diarrhea, or it can be on how to clean their infant's belly bottom and how to dress the wound around it. The theme can be on the importance of breastfeeding, and on how it can prevent babies to have diarrhea. There is an active campaign in Léôgane, which encourages breastfeeding. – The health agents are the one who announce the time and place of these weekly visits and keep the patients' health record, such as vaccination, case of malnutrition in the region, and bring the record to Sainte Croix hospital.

Q. How much it costs to deliver baby in Léôgane?

A. (Director): Delivery performed by traditional birth attendants in the mountain areas cost $150 Haitian dollar, for example in the Beauséjour area, which is 7 hours walking distance to the hospital. Delivery performed by midwives in the town cost $250, and $450 if the women deliver their baby at Sainte Croix hospital.

Q. What about maternal care?

A. (Community Doctor): In Léôgane, maternal health is given a lot of priority. The region has trained health agents to go to every remote community in the region to disseminate information about family planning, HIV/AIDS. We do focus group meeting with the community to know their needs. Also at these monthly health checkpoints, the health agents offer some sort of prenatal care; they are certain days allocated for prenatal services.

Q. Doctor, can you tell me more about the "Centre Maternel Communautaire" in Darbonne, being the coordinator of the Centre?

A. The Centre is situated at 3km walking distance from Léôgane. It is open to the population in general for consultation, Monday to Friday; we offer blood testing, and the specimens are sent to the lab at Sainte Croix hospital. We offer dental clinic on Saturdays. Like the Director already explained to you, we offer training to midwives and health agents in order for them to coach the traditional birth attendants who do the delivery in the remote areas. These training sessions are offered for a period of 4 months, 2 days a week. We have a registration system to register the number of maternal deaths in Darbonne, and we send these data to Sainte Croix hospital and to the Ministry of Health in Port-au-Prince. The health agents from other regions send their reports as well to Sainte Croix hospital.

Q. Do you keep a record on how many pregnant women visit the Centre?

A. (Community Doctor): There are a lot of pregnant women that visit the Centre, but unfortunately we don't record the number that comes. We do need to establish a better detailed recording system.

Q. Doctor, what are the causes of maternal mortality in the region of Léôgane?

A. The main cause of maternal death in this region is eclampsia. These are the most complicated cases because it is due to too early pregnancy. Young 15 years old girls who get pregnant and don't seek medical care; they hide their pregnancy until it is too late. These cases are very frequent in the region.

Other causes of maternal deaths in the region are long walking distance, lack of first-aid worker in the remote areas to offer assistance to mothers before they reach the hospital. Also lack of transportation and emergency system to bring mothers to the hospital during complication in labor. For instance in Beauséjour, which is at 7 hours walking distance to Sainte Croix hospital with no proper roads, the rate of maternal mortality there is very high.

Cost is another contributing factor to this problem. Women cannot afford to pay the asking fee to deliver their baby, so in those cases a member of their family with no training delivers the child.

Cases of tetanus and heamorrages after delivery are alarming. Most cases of maternal deaths occur after the delivery, and it happens frequently in the remote areas. Lack of tetanus vaccination for pregnant women is a big problem in the region.

Malaria is also a big problem in the region. A lot of pregnant women have malaria, which puts them at risk.

Problem with family planning impedes the positive impact that this planning could have on this problem.

Q. What kind of problem you are having with family planning?

A. (Community Doctor): Problem with machismo in the Haitian culture. The women are scared to participate in the family planning session because of their husband. Husbands control their wives by keeping them pregnant so with family planning they will lose that control and they believe that family planning gives women more control over their sexuality, therefore, they can become unfaithful. This is unfortunate, because when talking to women, they don't want to have a lot of children anymore. So because of this fear for their husband's reaction, they don't come to the sessions on family planning. This program is more successful when women come to the session with their husband. – There is a lot to be done still, a lot of education.

Q. In your opinion what should be done to really tackle maternal mortality in Léôgane?

A. (Director): More financial resources are needed to address this issue. Better emergency system, such as a well equipped ambulance. Good roads would give the hospital easy access to the remote areas and answer quickly to distress situation.

A. (Community Doctor): We need to take care of these young girls who are getting pregnant. We need to educate them about contraception, safe sex, and this kind of education should starts in school. We need to find ways to bring these women to the hospital when there is an emergency, or closer to a health facility when they are almost at the end of their pregnancy. We need to send more health agents in the remote areas and more trained midwives to do the delivery in the remote places. We need to educate the men, the husbands and teach them about the importance of family planning. We need to keep a better health record system for each woman who visits us in the Centre. Like this we will know their health history and treat them better.

Q. I know through my research that there are a lot of international NGOs that have maternal projects in Haiti. Is there any here? If yes, how come there is no improvement with their help?

A. (Community Doctor): Ah! These organizations come and go. There is no continuity in none of their health projects. So what that did, it has created a kind of mistrust toward these projects. The community sees that these projects begins and then stop. So when another international NGO comes with their health project, the people don't take it seriously and they don't come. You will be surprised, but people living in rural areas like regularity and consistency in everything. When you tell them something, they want to see a regular pattern to it, otherwise forget it.

A. (Financial Consultant): Maternal mortality in Léôgane and in Haiti as a whole is a development issue. There are deeper factors involved, such as economic factors, mostly, cultural factors, political factors, structural factors and other health factors involved that complicate these women's pregnancy and put them at risk. So, in order to really resolve this problem, who ever is doing it, has to address all these factors, and it takes time, money and goodwill.

Q. How about women's participation in the decision-making process regarding their health?

A. (Community Doctor): The women as well as men who are health agents are part of the decision-making for programs and activities in the region. Husbands and the chief of each community, usually a man also takes part in the process. But ordinary women in the community do not, and that should change. We realized that the women are the one who know exactly what they need and how they would like to have think done to benefit them, so this aspect needs to be improved.

The meeting ended in a very friendly tone. The Director offered me the hospital's Van with a driver and a security guard to drive me in various sites. Then, I joined Dr. Beau de Rochars in her office to schedule my site visits in various locations in Léôgane for the next two weeks.

My first visit was to the "Centre Maternel Communautaire" of Darbonne, 3 Km from downtown Léôgane. Both the community doctor and Dr. Beau de Rochars accompanied me in that visit, as well as two health agents who work at the Darbonne Centre. The condition of the road in the highway is good, but when we left the highway to enter Darbonne, the roads are very narrow and not paved. Some sections could be impracticable for a normal car, but we could go through with our four by four Van. The Centre is very clean and has a nice layout. I met with the head of the health agents who is responsible for the training of the midwives for all 13 sections in Léôgane. I also met other health agents who work at the Centre. They proudly showed me around, and brought me to different sections of the Centre, explaining how think works there. We spent the day at the Centre in Darbonne.

My next visit was in Grande-Rivière. It is situated at 10 km from the town of Léôgane. It has a surface of 34.06 square kilometers with a population of 20953 habitants (Division D'Analyse et de Recherche Démographiques, 1999). The purpose of my visit there was to go to the health stations. The location for health stations are in the health agents' house, where they set up tables and chairs in their front yard to receive mothers and their infant. When I asked the other passengers in the car if the health stations were always at an agent's house, they all answered yes. They explained that it is easy this way because there is no other alternative.

In Grande-Rivière, I had the opportunity to observe an outside clinic. The two doctors introduced me to the two health agents working that day. The clinic was at one of the agent's house and there were a great number of mothers with their children who showed up. There, under the watchful eye of the mothers one health agent vaccinated the children and weighed them in the little scale hanging on a tree, while the other agent was recording the names of the patients on a notepad, recording the weight of the children, the date of their vaccination. She was giving some vitamins to the children as well. Both health agents answered all of the questions asked by the mothers and gave them some advice as well. Every concerns expressed by the mothers concerning their children's health was recorded. I spent most of the day in that particular health station, and to my surprise there were close to one hundred patients who visited the clinic that day. Another element that I have observed is that there were no pregnant women visiting the health station, only mothers and their children. When I asked about the doctors about the absence of pregnant women, they replied that it might not be the day for prenatal visit. Then we stopped at other health stations, which were not as busy as the first one I visited.

After visiting Grande-Rivière, I went another day to Petite-Rivière. The village is also situated at 10 km from the town of Léôgane. Its surface is 33.86 square kilometers and with a population of 16,223 habitants (Division D'Analyse et de Recherche Démographique, 1999). I visited 5 health stations, located as well in the health agents' house. The number of patients varied from one station to the

other. Apparently some health agents are better known and better trusted than others, so most people go to the popular agents. All the agents that I have observed operated the same way: weighing of children, vaccinating them and recording information. Once again, there were no pregnant women on site for prenatal care.

Grande-Rivière and Petite-Rivière are among the remote areas of Léôgane. The population in these two places is very dense and it is very poor. There is no infrastructure, no proper transportation system. Put aside these health stations, which operate only during daytime, there no other health facilities in these areas except for Sainte Croix hospital situated at 10 km by car. While driving I could see the devastation all around; a lot of men and women are unemployed. There are no industries or much farming in the region. Léôgane's main industry is sugar cane, and the only plant that was processing the sugar cane is closed. So it really destroyed the economy of Léôgane and its surroundings.

However, despite the economic devastation in the region, the people of Léôgane are dynamics. In the town of Léôgane, eighty percent of street merchants are women. They are vibrant, business minded and they are truly the pillars of the 'Léôganaise' society.

After visiting Darbonne, Grande-Rivière and Petite- Rivière, I stayed few days in the town of Léôgane to visit other health centers in the downtown area, and to drive around the compound of the international NGOs. With the doctors I drove

pass some Christian-based organizations' compound, which looks very impressive from the outside. I also drove pass the compound of 'Doctors Without Borders'. Apparently the services that they provide are very efficient, and free. A lot of people in the region go to them. They also provide health care services in most part of the country, even in the most dangerous slams of the capital.

When I was touring the town of Léôgane, I had the opportunity to converse informally with the passengers in the car. They were all telling me about the devastating impact of the embargo on the economy, the physical infrastructure (electricity, road, potable water) and on the social structure of the country: health and education. It is a complete breakdown of all the system. Government's employees are not being paid regularly and there is very little investment in health services, in education programs and in rebuilding the infrastructure. They were saying that all the financial aid announced by the international community never has yet to come. The rate of malnutrition among children and women is at its highest. They told me that the government is trying its best, but there is still a long way to go.

Then I visited the "Centre Materno-Infantile" located in downtown Léôgane, 5 to 7 minutes walking distance from Hôpital Sainte Croix. This Centre is without beds and it is open Monday to Friday from 7 am to 3 pm. It serves mainly pregnant women and children. It offers prenatal care and offers primary care to children: vaccination, weighing. The Centre also offers family planning session and health education to women and their husbands.

Dr. Beau de Rochars called prior to my visit to arrange a meeting with the doctors responsible for the Centre. I wanted to meet them because it is a Centre for pregnant women, so I wanted to know from them if they have encountered other causes contributing to maternal deaths in the region. I wanted to know also how many pregnant women visited the Centre everyday. Unfortunately, when I arrived at the time scheduled for the meeting, no doctors were present. They didn't show up at all in the Centre according to one of the Administrative Assistant. Nevertheless, I didn't lose that day, because I met the family planning nurse and she demonstrated to me a contraceptive method that has been well accepted by women who come to these sessions. She also revealed to me that women followed and applied the instructions for family planning only when their husbands are involved. When the husbands come to the sessions with their wives, they take charge, and they make sure that their wives applied the contraceptive methods. – Maybe they are very interested in family planning because they realize its importance, or it is for them another opportunity to exercise control over their wives.

I also visited Hôpital Cardinal-Léger, only few minutes from Sainte Croix hospital. It is a very nice hospital run by Canadian nuns. The hospital is well equipped and well organized. Sometimes Cardinal-Leger hospital allows Sainte Croix hospital to use its facility, for instance to perform surgery. It also provides Sainte Croix with some medical supplies when needed. This hospital does not have an obstetric department because it offers services to the leprous. I met with Sister

Leblanc, the Head Nurse and Director of the hospital. I visited this hospital in order to establish for myself the amount of medical facilities available in this particular region and the type of services they offer to the population.

After my visit to Hôpital Cardinal-Leger that day, I returned to Hôpital Sainte Croix, where I had a tour of the hospital. I visited the maternity ward and other department of the hospital, such as the obstetric department. I was amazed to see the amount of women in the waiting room in the obstetric department. This makes me see that women living in rural areas do seek medical or prenatal care when such services are provided to them. The maternity ward at Sainte Croix is very clean and the medical care they provide to mothers is very good.

I also visited the section of Sainte Croix hospital where treatment and counseling is offered to HIV/AIDS patients. This program coordinated by Dr. Dayane Beau de Rochars is well managed and it is a great success. Pregnant women diagnosed with the AIDS virus are automatically taken in charge. They are provided with the antiviral drug, at no cost, they receive regular medical check up also at no cost and they are given dry food.

Following my tour of Sainte Croix hospital, I assisted a meeting between the doctors and the health agents who were giving their work report. The information that they gathered is brought to the hospital and then to be sent to the Ministry of Health. I was present in the meeting only as an observer. The health agents reported that in the previous week, five women died at home after giving birth.

For all five women, hemorrhage was the cause of death. Apparently these cases happen much too often in the remote areas of Léôgane. The doctors were very upset and concerned by this report. When the doctors asked the agents if they had recorded these deaths as maternal mortality, they replied no, the reason is that the women died after the delivery. The doctors requested that the agents recorded the deaths as maternal mortality.

After the meeting the doctors and myself discussed this situation. According to them, no postnatal care services are offered to women living in the remote and mountainous areas. After the delivery women are not put in observation in case something goes wrong, the birth attendants don't offer any follow up visits. Another reason for the cases of hemorrhages the doctors have explained is that according to women's tradition and belief in the rural areas they have to liberate themselves from the baby. So during the delivery, they push the baby with full force ignoring the request of the midwives or of doctors not to push, even when they are delivering their baby in the hospital. Thus, by pushing so hard they lacerate the neck of the womb, which causes a lot of bleeding during and after the delivery. If these women are left alone after giving birth with no monitoring, they bleed to death, like in these 5 cases. Therefore, they expressed the urgent need to establish, in the remote areas, follow up visits by health agents to mothers after they give birth. They expressed the need to educate women about birthing, also the need to teach to listen to instructions during delivery.

I returned to the "Centre Materno-Infantile" another day attempting to meet the doctors. Again with no success, once again they did not come to the Centre. When I asked one of the nurses why the doctors do not report to their post, she explained that because the Centre doesn't pay the doctors regularly, they had to open their own clinics, therefore, they give priority to their private clinics over the public one. They don't have a choice, she said. Apparently this is a real problem all over the rural areas of the country. Unfortunately, people's health is at stake because of this situation, and those who suffer the most are the people living in the rural and remote areas of the country and who are in desperate needs of medical care.

I was very saddened by this situation because the two times that I went to the Centre, I saw a lots of pregnant women who were there, some with their infants waiting to be seen by a doctor, either for themselves or for their child. Most of the time these women have to walk kilometers to visit these clinics or hospitals, so by not having a doctor present on a regular basis to provide treatment to the women and their children, deprive them of their right to health.

My last two site visits was in the region of Trouin and Beauséjour. The region of Trouin has a population of 372 habitants and Beauséjour with a population of 3266 (Division D'Analyse et de Recherche Démographiques, 1999).

Trouin is a two hours drive from the town of Léôgane. It is one of the most remote areas of Léôgane. Infrastructure is practically non-existent and the roads are treacherous. However, it is very scenic. There is one dispensary equipped

with one microscope. Two medical auxiliaries offer general consultation to the population, Monday to Friday from 8 am to 3 pm. When I arrived there, the dispensary was already opened to patients. There were a large 'mixte' group of men, women and children. I briefly talked to the auxiliaries and I spent the morning talking to patients and observing the activities of the day. The patients were a little reluctant to talk to me at first, but as the day goes by they were more willing to tell me why they were seeking medical attention. Then I took this opportunity to improvise a focus group meeting with some of the women patients. The idea behind this focus group meeting was to get the women's input about the health services that they are receiving. Also I wanted to know what kind of issues they are dealing with besides their health. The setting was informal, and the questions were unstructured. The language spoken at the focus group meeting was Creole. My firsts questions were open to everyone.

Q. How do you like this dispensary?

A. There was no answer at first. Then, one lady answered: **"**It's not too bad**".** It is not always regular.

Q. Do you come often to see the doctor?

A. Everyone spoke almost together: **"**When we can pay. We want to come when we feel something is wrong, but sometimes it is not possible because of money**"**. Also we come from far.

Q. How much the medical visit costs you?

A. 10 Gourdes

Q. Why are you seeing the doctor today? (Question to a pregnant woman)

A. (Pregnant woman) I had a fever, and the doctor told me that I have malaria.

Q. Did he prescribe you something?

A. (Pregnant woman) I have to get some pills.

Then the group of women suddenly thanked me and they left, some women joined the waiting line, others went home.

My last site visit was the village of Beauséjour. It is situated in the mountain at 7 hours walking distance from Hôpital Sainte Croix. There is a dispensary as well in the village with one medical auxiliary offering general consultation. This place is very remote and the road is completely impracticable. However, after several attempts to continue driving we had to stop. This was unfortunate; meeting with the medical auxiliary would provide me with more details on the causes of maternal mortality in this area because according to the Community Doctor the rate of maternal death in Beauséjour is the highest in regions surrounding Léôgane.

During the time period I was in Haiti, I have made several attempts to meet with government officials in Port-au-Prince, but I wasn't successful. Nevertheless, I have obtained some health statistics from the Community Doctor of Léôgane.

CHAPTER 6

GENERAL CONCLUSIONS

Haiti is a prime target for aid. Crippled by severe poverty, the country has been subject for decades to overseas aid delivered by NGOs, bilateral and multilateral agencies, churches and private donors dealing with diverse issues of development including health. Development projects have been organized by numerous international organizations, Non-Governmental Organizations (NGOs) and by the Haitian medical professional to improve the health situation for the poor and mostly to help reduce the rate of maternal death in the rural areas and the poor urban region of the country. However, despite all the international aid and health development projects over the years, the general health of the population, over 50% rate, is still deplorable. The rate of maternal mortality, an important condition of poverty and a common indicator of a population's state of health, reflects this situation.

The persistence of poverty as measured in economic or income terms, or in terms of health and other social or basic needs indicators raises a number of questions about the efficacy of the development project and overseas development assistance. One question is whether the structure itself of aid, traditionally top-down with very little community participation, might be a contributing cause of the apparent failure of the development effort in Haiti? Or is constant political instability a factor impeding all development progress in the country? Also what kind of development effort has been made to specifically

address the problem of high rate of maternal death? Could the lack of continuity or sustainability of these international projects be the factors of the failure of most health development projects in Haiti including health projects for maternal mortality? It is generally understood that economic and social development requires, and is predicated on structural change – social transformation or minimally institutional reform. Can aid effect such change?

The first step taken in search of an answer to some of these questions, and thereby an understanding of the dynamics of poverty and underdevelopment in Haiti, was a systematic review of both the academic literature related to the problem and development programs over the years.

One conclusion drawn from the literature is that health is a critical condition of poverty. In the academic of literature and policy / program analysis / evaluation poverty is most often portrayed as a problem of social exclusion from government program. However, findings has some scholars suggest that the roots of the problem go deeper into the economic and social structure of ownership or the lack of adequate access to society's productive resources. In any case, endemic poverty is reflected in diverse social conditions, particularly health. Conditions of ill health such as high maternal and infant mortality can be taken as clear indications of poverty, proxies for the lack of development. A second conclusion from the literature review is that the relative failure of so much development effort – decades of effort by the international organizations cooperating for development, government of the day and civil society and

communities – is due to both structural factors (the economic and social structure of Haitian society) and strategic considerations. In this regard in the 1980s the government of Haiti as elsewhere retreated somewhat from its responsibilities in the areas of economic and social development reaches a vacuum, a gap in remedial programming. With the assistance of a growing number of non-governmental organizations, this gap was filled by diverse community-based organizations, acting in partnership with the organizations for development, both bilateral and multilateral.

The problem of poverty and ill health have also resisted the efforts of these community-based or grassroots organization in Haiti's burgeoning civil society. These are clear indications that a self-help approach or effective participation of communities in the development process is a critical factor in the relative (albeit limited) successful outcomes achieved in the areas of health and poverty. Another critical factor is partnership with the Haitian government, local grassroots and the international communities in development process. The lack of partnership between the 3 actors makes it difficult for any development projects to be successful or to be sustainable. This partnership could enable local and international partners to share the responsibility in identifying priority needs, designing the response to these needs and acquiring the skills and resources required for the continuity and implementation of that response. In a partnership with the local grassroots the government will recognize and value the skills, resources, knowledge and capacity of their members, and will implement policies

allowing them to be included and to participate in the development process. But as demonstrated in the literature review, such step is yet to be applied in the development process in Haiti in order to see any kind of progress in that regard. Both Haitian's entrenched social and economic structure, and the economic growth' policies pursued by the government, tend to worsen rather than improve the lot of Haitian's poor, exacerbating their social exclusion and forcing them to rely on their inadequate resources in an economy geared to the private sector (of profit-making enterprises), and to do so without the support of public institutions. The overseas 'assistance' provided by a host of multilateral (intergovernmental) and bilateral (government) institutions in this context of a market economy cannot overcome or compensate for the structural forces and conditions generated by the existing social structure and government policies. Thus, to give development a chance, there is a need for both structural and policy change. Existing development programs oriented as they are towards poverty alleviation, and neoliberal policy of structural adjustment that exacerbates the problem, cannot provide a solution to the problem of poverty.

The thesis of this study is that a better solution is to be found in community-based development, the effective and full participation of grassroots/non-governmental organizations. However, community-based development (CBD) and popular participation by themselves cannot solve this problem; effective structural change is needed as well as a fundamental shift in government policy away from what the World Bank mistakenly terms 'pro-poor economic growth'

policy. What is needed is a change in government policy, a new policy regime supportive of a community-based approach to development and social development from within civil society and from below, that is, initiated from the grassroots.

As for the unacceptably high rate of maternal mortality and other such conditions of poverty in the country, it is argued that it is directly related to the lack of community participation and still the application of the top-down approach and/or strong external involvement on health policy and health programming in Haiti. Therefore, in order to improve maternal health and reduce maternal mortality in the country, three conditions of social change are needed. First, a change in government policy and approach allowing people from all path to be included in decision-making regarding their well-being and livelihood. Second, wide-range community involvement and broad-based community development in all health projects. Third, the involvement of the community in development initiatives and programs, which will bring continuity and sustainability to development and health projects in the country.

In short, the thesis of this study is that a solution of endemic poverty and maternal mortality in Haiti requires these three elements: change in government policy, community participation and strong community capacity-building for the sustainability of health projects.

My field research in Léôgane, Haiti a key to this study, has allowed me to evaluate the extent in which these three elements have been addressed and implemented to tackle the issue of maternal mortality in this region.

Information gathered from interviews and observation during my field research in Léôgane has pointed out to some changes in ways policy-makers and project developers view the concept of a new approach in development project. A self-approach and an effective participation of the community in the development process or development programs have been accepted by policy-makers as a solution to bring positive outcomes to development projects, particularly in projects in the areas of health. Partnership has been created between private institution and the government such as in the case between Hôpital Sainte Croix and the Ministry of Health to identify priority needs, design the response to these needs and to acquire the skills and resources required for the continuity and sustainability of that response. Therefore, policy-makers are willingly making an effort to include the community in programs or projects' activities, and to some extent to include them in the decision-making process.

However, in this new change of policy and attitude in development projects, the policy-makers at Sainte Croix hospital have overseen the importance to involve local women in any of the project activities and the benefit that their involvement could bring to the outcome of the maternal health projects in the Léôgane region. Despite the fact that local health agents and local midwives are involved in most decision-making process in maternal health programs for different regions of Léôgane, the approach still remains a top-down

approach because it is selective on who can or cannot participate. Women in the community and traditional birth attendants, the less trained groups, but the closest contact with pregnant women in the area and the first aid during deliveries are not involved in the decision-making process or in the implementation of any maternal health programs. Excluding the key people, in this case women, in these health programs planning and design concerning their well-being, could impede the sustainability of any maternal projects in Léôgane. As stated by White in his article: "When people have taken an active part in the planning and implementation of a project, they will collectively consider the completed project as their own". He also added: "If the people take an active part in the planning and design of the systems they will use, then the systems will be better adapted to their needs than if the solutions were coming from outsiders without consultations" (White, 1982: 25, 28).

However, policy makers and health officials in maternal health programs in Léôgane has realized the need to consult and involve local women in the implementation process of their projects and to continue building the capacity of the community in order to obtain positive outcomes in their programs.

The country's poor infrastructure (poor road condition, lack of electricity, water and sanitation) continues to have a negative impact on any development projects, and delays the delivery of services with regard to maternal health projects in Léôgane. This condition aggravated by 3 years sanctions led by the UN has created a persisting economic and politic chaos in the country, which makes it more difficult for government officials to implement and sustain any

effective structural change. Nevertheless, the outlook for change in government policy and in policy supportive of a community-based approach to address the issue of maternal mortality in Léôgane and in the whole country is very positive.

BIBLIOGRAPHY

Ahluwalia, I., Kouletio, M., Curtis, K. and Schmid, T. "Community empowerment: CDC collaboration with the CARE Community-Based Reproductive Health Project in two districts in Tanzania", Journal Women's Health Gender-Based Med., 1999, Vol.8, p. 1015-1019.

Ahluwalia, I., Schmid, T., Kouletio, M., "Community Empowerment: CDC collaboration with the CARE Community Based Reproductive Health Project in two districts in Tanzania", J Womens Health Gender-Based Med., 1999, Vol. 8, pp. 1015-1019.

Ahmad, Kabir "Patients Health Assembly Debates & Effects of Globalization on Health Care", 2000, Lancet, Vol. 356,1:9247, pp. 2-3.

Ahmed, M. "Community participation: the hearth of PHC", Assignment Children, Vol. 42, Apr-Jun 1978, p. 80-99.

Alleyne, A.O. George, "Health in Haiti", Revista Panamericana de Salud Publica/Public Health, 2001, 10(3): 149-151

Amit, Sen Gu, *People's Democracy,* Sept. 22, 2002, Vol. XXVI, No. 37, pp. 1-3. Accessed from the website at http://pd.Cpim.org/2002/Sept22/09152002_ind.htm

Arnstein, S. "A ladder of citizen participation", American Institute of Planners Journal, Jul. 1969, p. 216-224.

Asuzu, M. "Self-reliance in the village", World Health, Mar 1990, p. 14-15.

Baer C. Franklin, "NGOs and Women's Health Services in Haiti: Three Case Studies", Second Draft, June 30, 1999, pp. 1-38.

Ballweg, JA, Webb, RE, and Biamby, G. "Mortality and the acceptability of family planning in a Haitian community", Community Health (Bristol), May-Jun.1974, Vol.5, I: 6, p. 304-11.

Banque de la République d'Haïti & Ministère des Finances, "HAITI, Introductary and Statistical Survey", 2000.

Barnes-Josiah, D. et al., 1993. Maternal Mortality in Haïti: Report and Evaluation from a National Study. Port-au-Prince: Institut Haïtien de L'Enfance de Pétionville.Bart, Jacobs and Price, Neil, "Community participation in external funded health projects: lessons from Cambodia", Health Policy and Planning, Dec. 2003, 18:4, pp. 399-410.

BASICS II, "Basics I Country Program: Haiti", pp. 1-6. Accessed from Website at wysiwyg://50/http://www.basics.org/programs/basics1/Haiti.html

Bhasin, K. "Participatory development demands participatory training", Convergence, 1991, Vol.24, I: 4, P. 5-15.

Bichmann, W. Community involvement in Nepal's health system: a case study of district health services management and the community health leader scheme in Kaski district, 1987, Dissertation paper.

Boserup, Ester, Women's Role in Economic Development, 1970, George Allen and Unwin LTD, London: 15-35.

Bowie, Stan L. and Potocky Miriam, "Social Service and Health Organizations in Haïti: A Resource Assessment", Social Development Issues, Vol. 20(1), 1998, pp. 77-90.

Brodwin, Paul E. "Politics, Practical Logic, and Primary Health Care in Rural Haïti", Medical Anthropology Quarterly, Mar.1997, Vol. 11, No. 1, p. 69-83.

Brokensha, D. & Hodge, P., Community development: an interpretation, Novato, CA, Chandler & Sharp Publications, 1969.

Burkey, Stan, People First, A Guide to Self-Reliant, Participatory Rural Development, 1993, Zed Books LTD, London and New Jersey: 34-57.

Canadian Journal of Sociology / Cahiers Canadiens de Sociologie, "In Faint Praise of the World Bank's Gender Development Policy", 2005, 30: 1, pp. 1-19. Accessed from website at http://www.cjsonline.ca/articles/brymetal05.html

CARE International Haiti, 1995. A Baseline Study of Livelihood Security in Northwest Haïti (draft report). Port-au-Prince: CARE International Haiti.

CARE's project work, Haiti. Accessed from Website at http://www.careinternational.org.uk/cares_work/where/haiti/reports/haiti_projects.htm

Cayemittes, M., Rival, A., Barrère, B., Lerebours, G., Gédéon, M.A., "Enquête Mortalité, Morbidité et Utilisation des Services (EMMUS-II) Haïti 1994/95", Le Centre International de Documentation et d'Information Haïtienne Caraïbéenne et Afro-Canadienne (CIDIHCA), Décembre 1995.

Chambers, R Rural Development: Putting the Last First, 1983, Longman Group Ltd: New York

Chambers, R, Paradigm shifts and the Practice of Participation, In Nelson, N. and Wright, S. Power and Participatory Development: Theory and Practice, 1995, Intermediate Technology Publications Ltd, London.

Child Health Institute, 1993. Haïti National Contraceptive Prevalence Survey. Atlanta, Georgia: Center for Disease Control.

Choguill Guaraldo, Marisa B., "A Ladder of Community Participation for Underdeveloped Countries", Habitat Intl., 1996, Vol. 20, No. 3, pp. 431-444.

Chowdhury, Morshed "Community participation in health care", Bulletin of the World Health Organization, Nov. 2004, 82:11.

Clark, B. D. "The concept of community: a reexamination", Sociological Review, 1973, Vol.21, I: 3, p. 32-38.

Cohen, Joshuaa dn Joel Rogers. 2000. Is Inequality Bad for Our Health?, Boston: Beacon Press.

Collymore, Yvette, "Haïti's Health Indicators Reflect Its Political and Economic Pains", Population Reference Bureau (PRB), 2004, accessed online at: www.prb.org/Template.cfm?Section=PRB&template=/ContentManagement/

Coreil, J. "Parallel structures in professional and folk health care: a model applied to rural Haïti", Cultural Medicine and Psychology 7, 1983, p. 131-151.

Cornia, Giovanni Andrea, Jolly, Richard and Stewart, Frances, "Adjustment with a Human Face: Protecting the Vulnerable and Promoting Growth", 1987, Vol. 1, Oxford UK: Oxford University Press.

"Coverage of Maternity Care: A Listing of Available Information (in press)", *World Health Organization,* Geneva, 1997.

Declaration of Alma Ata, Accessed from the website at http://www.euro.who.int/AboutWHO/Policy/20010827_l

Département de Santé et de la Population, 1984, "Programme d'entrainement des Matrones. Division d'Hygiene Familiale et de Nutrition", Ateliers Fardin, Port-au-Prince, Haïti.

Dodard, Michel, Fournier, Arthur, M., "The Health Care Delivery Crisis in Haïti", Family Medicine, 1997, Vol. 29 No. 9, pp. 666-669.

DYING FOR CHANGE: Poor people's experience of health and ill-health. Accessed from Website at http://www.siteresources.worldbank.org/INTPAH/Resources/Publications/Dying-for-change/dyifull2.pdf

Ekins, Paul, A New World Order, Grassroots Movements for Global Change, 1992, Routledge, London: 99-100.

Ekins, Paul & Max-Neef, Manfred, Real Life Economics: Understanding Wealth Creation, 1992, Routledge, London and New York: 197-215.

Elmendorf M L, "Women-the underused human resource: education and training of women for community participation", Educ Med Salud, 1982, 16 (4): 463-83.

Elson, Diane, "Gender Awareness in Modeling Structural Adjustment", 1995, World Development, 23: 1851-1868.

Embry M. Howell; Devaney Barbara; McCormick Marie; Raykovich Karen Thiel, "Back to the Future: Community Involvement in the Healthy Start Program", Journal of Health Politics, Policy and law, April 1998, Vol. 23, No. 2 p 292-317.

Estes, R.J., "Toward sustainable development: From theory to praxis", Social Development Issues, 1993, Vol. 15, pp. 1-29.

Eyben, R. and Ladbury S. July 1992. "Popular Participation in Aid Programmes: Why More in Theory than in Practice?". Paper presented to GAPP Conference on Participatory Development.

Fauveau, V; Stewart, K, "Effect on mortality of community-based maternity-care programme in rural Bangladesh", Lancet, 11/9/91, Vol. 338, Issue 8776, p. 1183.

Ferrell, B J A G, "Community development and health project: a 5 year (1995-1999) experience in Mozambique, Africa [in process]", Int. Nurs. Rev., Mar 2002, 49 (1): 27-37.

Freedman, L. P. and Maine, D. 1993. Women's mortality: a legacy of neglect. In the Health of Women: A Global Perspective, Boulder, CO., Westview Press, p. 147-170.

Freidmann, John, The Politics of Alternative Development, 1992, Blackwell: Cambridge, Mass.

Freire, Paulo, Pedagogy of the Oppressed, 1983, New York.

Friedmann, John. 1992. Review of Empowerment: The Politics of Alternative Development, Oxford: Blackwell, p. 55-71.

Gagnon, AJ "The training and integration of village health workers", Bull Pan Am Health Organ, 1991, Vol.25, I: 2, p. 127-38.

Galabuzi, Grace-Edward, "Social Inclusion as a Determinant of Health", Public Health Agency of Canada, 2003, pp. 1-8. Accessed from Website at http://www.phac-aspc.gc.ca/ph-sp/phdd/overview_implications/03_inclusion.html

Garfield, Richard and Holtz, Timothy H. 2000. "Health System Reforms in Cuba in the 1990s", In Healthcare Reform and Poverty in Latin America, ed. Peter Lloyd-Sherlock, 112-127. London: Institute of Latin American Studies, University of London.

Garrin, G. and Politi, C., "Poverty and Health: An Overview of the Basic Linkages and Public Policy Measures", World Health Organization Task Force on Health Economics, Geneva, 1997.

Gibbons, Elizabeth; Garfield, Richard, "The Impact of Economic Sanctions on Health and Human rights in Haïti, 1991-1994", American Journal of Public Health, Oct. 99, Vol. 89, I: 10, p. 1499.

Global Health Action, "Decreasing Maternal Deaths on the Island of La Gonave, Haiti" Accessed from Website at http://www.globalhealthaction.org/press-maternalhealth.html

Goodburn, E, Campbell, O., "Reducing Maternal Mortality in the Developing World: Sector-Wide Approaches May Be The Key", BMJ, 2001, Vol. 322, pp. 917-920.

Goodburn, E., Campbell, O. "Reducing maternal mortality in the developing world: sector-wide approaches may be the key", BMJ, 2001, Vol. 322, p. 917-920.

Goodwin, Neva. 2001. Civil Economy and Civilized Economics: Essentials for Sustainable Development. Tufts University. Global Development and Environment Institute Working Paper No. 01-01 (January 2001).

Gow, David D. and Vansant, Jerry, "Beyond the Rhetoric of Rural Development Participation: How Can It Be Done?", World Development, 1983, Vol. 11, No. 5, pp. 427-446.

Grafton, Quentin R., Rowlands, Dane, "Development Impeding Institutions: The Political Economy of Haïti", Canadian Journal of Development Studies, XVII, 2, 1996, pp. 262-275.

Graham, W., Brass, W. and Snow, R. W. "Estimating maternal mortality: the sisterhood method", Studies in Family Planning, 1989, Vol.20, I: 3, p. 125-135.

Gran, Guy, 1983. Development by People: Citizen Construction of a Just World, New York: Praeger, viii.

Gregory, S. "Health care overseas: health care in Haïti", Nurs. Times, Apr.1980, Vol.76, I: 15, p. 660-2.

Grossman, J. 1990. Health education: the leading edge of primary health care and maternal and child health. In Health Care of Women and Children in Developing Countries, Oakdale, CA., Third Party Publishing, p. 56-67.

Guest, Ian "Haiti beyond the headlines", POPULI, Nov. 1994, Vol 21, No 10, pp. 12-13.

Haiti Action Committee, March 2004. Accessed from Website at http://www.thirdworldtraveler.com/Haiti/US_War_Against_Haiti.html

Haiti Development Profile, May 2006. Accessed from Website at http://lcweb2.loc.gov/frd/cs/profiles/Haiti.pdf

Haiti Outreach – Pwoje Espwa (Project Hope), pp. 1-3. Accessed from Website at http://www.haitimedical.com/hope

Haiti Progress, "The Neoliberal Agenda in Haiti: An Interview with Camille Chalmers", July 3, 2002, Vol. 20, No. 16. http://www.haitiprogress.com/2002/sm020703/eng07-03.html

Hall, Anthony, "Community participation and development policy: a sociological perspective", p. 91-107 (source unknown)

Health Communication Partnership, "Haiti". Accessed from Website at http://www.hcpartnership.org/Programs/Latin_America/hcp_haiti.php

Hettne, Bjorn Development Theory and the Three Worlds: Dimensions of Another Development, 1990, Longman: London.

Howell, Embry M. et al., "Back to the Future: Community Involvement in the Healthy Start Program", Journal of Health Politics, Policy and Law, Vol. 23, No. 2, April 1998, pp. 291-317.

Iannotti, L., 1996. Haïti, Nutrition Situation and Program Assessment. Monograph, Medford Massachusetts: Tufts University.

Iatridis, Demetrius S. "Cuba's Health Care Policy: Prevention and Active Community Participation", Social Work, Jan. 1990, pp. 29-34.

Indu Ahluwalia; Michelle Kouletio, "Community Empowerment: CDC Collaboration with the Care Community-Based Reproductive Health Project in Two Districts in Tanzania", Journal of Women's Health & Gender-Based Medicine, 1999, Vol. 8, No. 8, p. 1015-19.

Inter-American Development Bank, 1992. Haïti Socioeconomic Report. Washington, D.C. : Inter-American Development Bank.

International Forum on Globalization. 2001. Does Globalization Help the Poor? San Francisco, August 2001.

International Child Care, 2003, "ICC Improves Child Health and Survival Through Reproductive Health Education". Accessed from Website at http://www.intlchildcare.org

Jacques Van der Gaag; Tania Barham, "Health and Health Expenditures in Adjusting and Non-Adjusting Countries", Soc. Sci. Med., 1998, Vol. 46, No. 8, pp. 995-1009.

Jeong, Ho-Won, "Alternative development strategies and regeneration of social space for human development", Peace & Change, Jul. 95, Vol. 20, Issue 3, pp. 1-13.

Joseph, Molly, Women Participation and Development Strategies, 1997, Kanishka Publishers, New Delhi: 63-77 / 77-87.

Josiah-Barnes, Debora, Myntti, Cynthia & Augustin, Antoine, "The "Three Delays" As A Framework For Examining Maternal Mortality In Haïti", Social Science & Medicine, Apr.1998, Vol. 46, No. 8, p. 981-993.

Kahsay, Haile Mariam, "Community involvement in health development", (Dal) WA 546.1, C 7346, 1999.

Kawachi, Ichiro, Kennedy, Bruce P. and Wilkinson, Richard G., eds. 1999. The Society and Population Health Reader, Vol. 1. New York: The New Press.

Kelly, K.J. and Van Vlaenderen, H., "Dynamics of Participation in a Community Heatlh Project", Social Sciences & Medicine, 1996, 42(9): 1235-1246.

Kilonzo, Andrew et al. "Improving Surveillance for Maternal and Perinatal Health in 2 Districts of Rural Tanzania", American Journal of Public Health, Oct. 2001, Vol. 91, Issue 10, 9p.

Kinoti, Kathambi, "Aid Effectiveness: Women's rights concerns", Aug. 10, 2007 AWID Friday File, pp. 1-4. Accessed from Website at http://www.awid.org

Korten, David, "Community Organization and Rural Development: A Learning Process Approach", Public Administration Review (PAR), p15.

Korten, David & Klauss, Rudi, People-Centered Development, 1984, Kumarian Press, Connecticut: 201-202.

La Jolla and de Sherbinin, Alex "Human security and fertility: The case of Haïti", Journal of Environment & Development, Mar. 1996, Vol.5, I: 1, p. 28.

Labonte, Ronald. 2000 "International Health Presence in Future World Trade / Investment Talks". In Health and Human Development in the Americas: The Contribution and Perspectives of Civil Society in the Americas, eds. A. Bambas, J.A. Casas, H.A. Drayton & A. Valdes, 105-120. Washington, D.C.: PAHO.

Landry, Robert, "Healers new and old: medical care in Haïti", IDRC reports, 1987, Vol.16, no. 3, p. 22.

Lee, H. and Bodadilla, J.L., 1994. "Health Statistics for the Americas", World Bank Technical Paper Number 262. Washington, D.C.: World Bank.

Leontien Laterveer, Louis W. Niessen, Abdo S. Yazbeck, "Pro-poor health policies in poverty reduction strategies", Health Policy and Planning, June 2003, 18(2):138-145, ABI / INFORM Global.

Lindsey, Elizabeth, Stajduhar, Kelli, McGuinness, Lisa, "Examining The Process Of Community Development", Journal of Advanced Nursing, Mar 2001, 33:6, pp. 828-835.

Lisk, Franklyn (ed.), "Conditions for Promoting Popular Participation in the Development Process", Popular Participating in Planning for Basic Needs: Concepts, Methods and Practices, 1985, a study prepared for the International Labour office within the framework of the World Employment Programme, St. Martins Press, New York.

Lundahl, Mats, Ruben, Silie, "Economic reform in Haiti: Past failures and future success?", Comparative Economic Studies, Spring 98, Vol. 40, Issue 1, pp. 1-23.

MacMillan, Neale, "Reducing Maternal and Infant Mortality in Indonesia", IDRC Report, 1999 Ottawa, ON. Accessed online at www.idrc.ca/reports/prn_report.cfm

Maine D; Akalin M Z; Chakraborty J; de Francisco A; Strong M, "Why did maternal mortality decline in Matlab?", Stud. Fam. Plann, Jul-Aug 1996, 27 (4): 179-87.

Maine, D. "Safe Motherhood Programs: Options and Issues", Center for Population and Family Health, 1991, Columbia University, New York.

Maine, D., McCarthy, J. and Ward, V. M. 1992. Guidelines for Monitoring Progress in the Reduction of Maternal Mortality, Statistics and Monitoring Section, UNICEF.

Mandl, P. "Community participation today: some current issues and lessons learned", Assignment Children, 59/60, 1982: 2, p. 9-14.

Martin, Patricia A., "Community Participation in Health and Population Programs", Economic Development Institute of the World Bank, March 1989, pp. 2-55.

Martinussen, John, Society, State and Market: People Managed Development, 1997, (chapter 24).

Mavoux, Linda "Beyond Naivety: Women, Gender Inequality and Participatory Development", Development and Change, 1995, Vol. 26, pp. 235-255.

Max-Neef, Manfred, Human Scale Development, 1991, The Apex Press, London & New York: 3-4.

McMaster University and the State University of Haiti / NGO affiliate: International Child Care, "Haïti: A Women's Health Initiative UPCDP Tier 2 Project 098/S74047-346, January 2002 to December 2008.

Méchin, Bernard, "Community health in Haïti: participation is the key", IDRC reports, 1978, Vol. 7, No. 3, p. 3-5.

Med. Trop., Mar.1999, Vol.59, I: 2, p. 129-35.

Mensch, B. S. 1993. Quality of care: a neglected dimension. In The Health of Women: A Global Perspective, Boulder, CO. Westview Press, p. 235-253.

Ministère de la Santé Publique et de la Population, "Quelques pistes pour aborder nos problèmes sanitaires", Port-au-Prince, Haïti, March 1994.

Morgan, Lynn M. "Community Participation in Health: perpetual allure, persistent challenge", Health Policy and Planning, Sept. 2001, 16:3, ABI / INFORM Global, pp.221-230.

Morton, L. Alice, "HAITI: NGO SECTOR STUDY", Private Sector Assistance, RONCO, USAID/Haiti, 1988, pp. 1-64.

Moser, C. "Gender planning in the third world: meeting practical and strategic gender needs", World development, 1989, Vol.17, I: 11, p. 1799-1825.

Moses, Stephen, "Organization of Primary Health Care Services (Haïti)", IDRC Research Project, 1988.

Mosquera M; Zapata Y; Lee K; Arango C; Varela A, "Strengthening user participation through health sector reform in Columbia: a study of institutional change and social representation", Health Policy Plan, Dec 2001, 16 Suppl 2: 52-60.

MSF in Haiti, 2004. Accessed from Website at http://www.msf.org/countries/index.cfm

Murtaza, Niaz, "Organizational Innovations in Third World Rural Development: A Balance Sheet of Successes and Failures", Social Development Issues, 1995, Vol. 17, pp. 89-103.

Nelson , N. and Wright, Power and Participatory Development: Theory and Practice, 1995, Intermediate Technology Publications Ltd, London.

NFE Exchange, 1981. "Can Participation Enhance Development", East Lansing: Institute for International Studies, Michigan State University, No.20, p. 1-7.

Nickson, P.J., "Community Participation in Health Care: who participate with whom", April 1991, Tropical Doctor, 21: 75-77.

Nugroho, Gunawan, "Partnership for community health development", World-Health-Forum, 1993, I: 14, no. 2, p. 168-71.

Nunnery, J. 1992. To what extent do traditional birth attendants in rural Haïti perform risk assessment during the antepartum period?, Unpublished masters' thesis, Emory University, Atlanta, GA

Nynorsk, Samegiella "Health, poverty and development: Norwegian perspectives and inputs to the WSSD process", UTENRIKSDEPARTEMENTET. Accessed from Website at http://www.dep.no/ud/norsk/p30000969/p30000916/p10003047/032001-990603/dok-bn.html

N'Zengou-Tayo, Marie-Jose, "Fanm Se Poto Mitan: Haitian Women, The Pillar of Society", Feminist Review, No. 59, Summer 1998, pp. 118-142.

O'Malley, Anthony, The Role of "Community" in Development Analysis, 1998, Working Paper No. 98.10.1. International Development Studies Program, Halifax: Saint Mary's University.

Oakley Peter and Kahssay Haile Mariam, "Community involvement in health development: a review of the concept and practice", *World Health Organization,* 1999, Geneva.

Oakley, P. "Community involvement in health development: An examination of the critical issues", WHO, Geneva, 1989, p. 1-2; 10-14.

Oakley, P. et al. 1991. Projects with People: the Practice of Participation in rural Development, Geneva: International Labor Organization.

Oakley, Peter et al., "Projects with People: The practice of participation in rural development", *International Labour Office,* 1991, Geneva.

Oakley, Peter, "Community Involvement in Health Development: An examination of the critical issues", World Health Organization, 1989, Geneva.

Organisation Développement et Paix, "Programme Pays: Haïti", Programmation 2003-2006.

Organisation for Economic Co-operation and Development (OECD), "Participatory Development and Good Governance, Development Co-operation Guidelines Series", OECD Publications, 1995.

Organization For Economic Co-Operation And Development (OECD), Participatory Development From Advocacy to Action, 1995, OECD, Paris: 10-13.

Ozcebe, Hilal & Akin, Levent (Associate Professors), "Correspondence: Community participation in primary health care", Journal of Public Health Medicine, 20(2): 234-240

PAHO / WHO / Ministry of Public Health and Population, "Health Situation Analysis", Haïti 1996

Pan American Health Organisation (PAHO), 1984. Community Participation in health and development in the Americas: An analysis of selected case studies, Scientific Publication, No.473, PAHO: Washington D. C.

Pan American Health Organization (PAHO), "Community Participation in Health and Development in the Americas". Scientific Publication No. 473, Washington, DC, 1984.

Pan American Health Organization / World Health Organization. "Health humanitarian assistance program. Report on PAHO/WHO activities", October 1991-July 1994, Port-au-Prince, Haïti: August 1994.

Pan American Health Organization / World Health Organization, "Haiti: Basic Country Health Profiles, Summaries 1999", Data updated for 2001, pp. 1-20. Accessed from website at http://www.paho.org/english/sha/prflhai.htm

Parry, Jayne & Wright, John "Community participation in health impact assessments: intuitively appealing but practically difficult", Bulletin of the World Health Organization, 2003, 81(6): 388

Partners In Health / Zanmi Lasante, "Haiti: Partner Overview", July 2005. Accessed from Website at http://www.pih.org/wherewework/haiti/index.html

Pearson, Ruth, "Rethinking Gender Matters in Development", 2000, Oxford UK: Oxford University Press, pp.383-402.

Perito, Robert and Hsu, Emily "Haiti's Economic Challenge", July 2006. Accessed from Website at http://www.usip.org/pubs/usipeace_briefings/2006/0717_haiti_economy.html

Pillsbury, B., Brownlee, A. and Timyan, J., Understanding and Evaluating Traditional Practices: A Guide for Improving Maternal Care, *International Centre for Research on Women, Maternal Nutrition and Health Care Program,* Washington, DC., 1990.

Presentation and working group recommendations on *Addressing Financial and Economic Barriers to Improving Access to Quality Maternal Health Services.* Safe Motherhood Technical Consultation in Sri Lanka, 18-23 October 1997.

Raccurt, CP. "[Haïti: health in one of the planet's poorest countries?]. Haïti: quelle santé pour un des pays les plus pauvres de la planète?".

Racelis, Mary, The United Nations Children's Fund: Expression With People's Participation, in *183 World Bank Discussion Papers, Participatory Development and the World Bank,* 1992, The World Bank, Washington DC: 59-64.

Rauyajin, Oratai; Yoddumnern-Attig, Bencha, "Social Cost of Maternal Deaths", World Health, May/Jun 93, Vol. 46, Issue 3, p 26.

Reuss, Alejandro. 2000. "Cause of Death: Inequality". Dollars & Sense, May / June, 10-12.

Rifkin, Susan B. "Community Participation in Maternal and Child Health / Family Planning Programmes", World Health Organization, 1990.

Rifkin Susan B., "Lessons from community participation in health programs", 1986, Health Policy and Planning, 1(3): 240-249.

Rifkin, Susan B., Frits Muller & Wolfgang Bichmann, "Primary Health Care: On Measuring Participation", Soc. Sci. Med., 1988, Vol. 26, No 9, pp. 931-940.

Roberto Castro et al., "A Study on Maternal Mortality in Mexico Through a Qualitative Approach", Journal of Women's Health & Gender-Based Medicine, 2000, Vol. 9, No. 6, pp. 679-690.

Rohter, Larry, "Quarrel Imperils Health Care in Haïti", Foreign Desk, May 1996, Section 1, Column 1, p. 10.

Ronsmans, Carrie; Vanneste, Anne-Marie; "Decline in maternal mortality in Matlab, Bangladesh: A cautionary tale", Lancet, 12/20/97, Vol. 350, Issue 9094, p. 1810.

Sauveur Pierre Etienne, "Haïti: L'Invasion des ONG", Les Editions du CIDIHCA.

Schmid, Thomas et al. "Transportation for Maternal Emergencies in Tanzania: Empowering Communities Through Participatory Problem Solving", American Journal of Public Health, Oct. 2001, Vol. 91, Issue 10, 5p.

Schmid, Thomas, Kanenda, Omari; Ahluwalia, Indu; Kouletio, Michelle, "Transportation for Maternal Emergencies in Tanzania: Empowering Communities Through Participatory Problem Solving", American Journal of Public Health, Oct 2001, Vol. 91, Issue 10, p 1589.

Schumacher, E.F., "Dimensions of Another Development", Development Theory and the Three Worlds, Chapter 5, pp. 152-189.

Schuyler, George W. "Globalization and Health: Venezuela and Cuba", Canadian Journal of Development Studies, 2002, Volume XXIII, No. 4,pp. 687-716.

Smucker, J. 1981. The Role of Rural Haitian Women In Development. Port-au-Prince: USAID.

Stiefel, Matthias and Wolfe, Marshall, "The Quest for Participation", United Nations Research Institute for Social Development (UNRISD) report, June 1984.

Stiefel, Matthias and Wolfe, Marshall, A Voice for the Excluded, Popular Participation in Development: Utopia or Necessity?, 1994, Zed Books LTD, London & New Jersey: 3-213.

Stiefel, M. and Wolfe, M., "Development in Poverty Reduction Strategies: An Analysis for the Contributions of Participation", 1984. Accessed from http://idd.bham.ac.ukStillwagon, Eileen. 1998. Stunted Lives, Stagnant Economies: Poverty, Disease and Underdevelopment. New Brunswick, N.J.: Rutgers University Press.

Stone, Linda, "Cultural Influences in Community Participation in Health", Social Science & Medicine, 1992, 35(4): 409-417.

Sundari, T.K. "The untold story: how the health care system in developing countries contribute to maternal mortality", International Journal of Health Services 22, 513-528.

Tardif, F., 1991. La Situation des Femmes Haïtiennes. Port-au-Prince: Comité Inter-Agences Femmes et Développement Système des Nations Unies.

Tazairy, Idriss et. al. "From the old to the new development paradigm", The State of World Rural Poverty. International Fund for Agriculture Development, 1993, pp. 1-29.

Thaddeus, S. and Maine, D. "Too far to walk: maternal mortality in context", Social Science and Medicine, 1994, Vol. 38, p. 1091-1110.

Therien, Jean-Phillippe "Non-governmental Organizations and International Development Assistance", Department of Political Science, University of Montreal, 1991, pp.263-278

The World Bank Group, June 1998. "Sri Lanka's Health Sector: Achievements and Challenges". Accessed online at http://wbln1018.worldbank.org/sar/sa.nsf/

The World Bank Group, June 2000. "Haiti Country Brief". Accessed online at http://Inweb18.worldbank.org/external/lac/lac.nsf

The Rockefeller Foundation & Swedish International Development Cooperation Agency, "Challenging Inequities in Health: from ethics to action". Accessed from Website at http://www.rockfound.org/Documents/435/summary_challenging.pdf

Timyan, J., Griffey, Brechin, S.J., Measham, D.M. and Ogunleye, B. 1993. Access to care: more than a problem of distance. In The Health of Women: A Global Perspective, Boulder, CO. Westview Press.

UNICEF, 1994. Analyse de la Situation des Femmes et des Enfants en Haïti (Période 1980-1993). Port-au-Prince: UNICEF, Haïti.

United Nations Development Program (UNDP). 2001, 2000, 1999, 1997, 1996, 1993, 1992, 1990. Human Development Report 1990-2001. New York: UNDP / Oxford University Press.

University of Arizona, 1995. A Baseline Study of Livelihood Security in the Southern Penninsula of Haiti (draft report). University of Arizona.

Veltmeyer, Henry and O'Malley, Anthony, "The Quest for Another Development", extracted from: Transcending Neoliberalism. Community-Based Development in Latin-America, 2001, Bloomfield, CT, Kumarian Press,Inc: 1-32.

Veltmeyer, Henry, The Dynamics of Inter-Sectoral Alliances and Urban-Rural Linkages, Commissioned Thematic Paper, UNRISD, 2001.

Veltmeyer, Henry. 1999. The Labyrinth of Latin American Development. New Delhi: A. P. H. Publishing.

Veltmeyer, Henry and Petras, James, The Dynamics of Social Change in Latin America, 2000, Palgrave, Hampshire and New York: 36-41.

Verly, A. et al. 1995. "La Grossesse Chez les Jeunes". Port-au-Prince: Pan American Health Organization / World Health Organization.

Vimala, Charles "Community Development – An Entry Point For Community Participation In Health Programme", Indian Journal Of Public Health, April-June 1987, XXXI(2): 104-108.

Vincent De Brouwere; Rene Tonglet; Wim Van Lerberghe, "Strategies for reducing maternal mortality in developing countries: what can we learn from the history of the industrialized West?", Tropical Medicine and International Health, Oct 1998, Vol 3, No 10, p 771-782.

Voltaire, Henri-Claude, "Les Unités Communales de Santé: Principes et Orientations Stratétiques", Ministère de la Santé Publique et de la Population, & Organisation Panaméricaine de la Santé / Organisation Mondiale de la Santé, Port-au-Prince, Haïti, Juin 1999.

VOLUME II: Technical Papers / HAïTI: The Challenges of Poverty Reduction, Report No. 17242-HA, August 1998

Charlier, Garry L.M., "Review Of The Impact And Effectiveness Of Donor-Financed Emergency Poverty Alleviation Projects In Haïti: Related To Basic Infrastructure Rehabilitation And Employment Generation", pp. 1-41.

Correia, Maria, "Gender And Poverty In Haïti", pp. 1-17.

Currelly, John, "Microenterprise Development And Job Creation In Haiti", pp.1-27.

Gagnon, Gerard, "Food Security Issues In Haïti", pp. 1-36.

Morton, Alice L. "NGO Sector Study", pp. 1-63.

Salmi, Jamil, "Equity And Quality In Private Education: The Haitian Paradox", pp. 1-17.

Schneidman, Miriam and Levine, Ruth, "Health And Nutrition Sectors", pp. 1-11. (copy from Haitian Library in Montreal)

Wiens, Thomas and Sobrado, Carlos E., "Rural Poverty in Haïti", pp.1-46.

Smucker, Glenn R., and White, Anderson T., "Social Capital And Governance In Haïti: Traditions And Trends", pp. 7- 34.

Walraven, Gijs and Weeks, Andrew, "The Role of (traditional) birth attendants with midwifery skills in the reduction of maternal mortality", Tropical Medicine and International Health, Aug.1999, Vol. 4, No. 8, p. 527-529.

Ward, Martha C. "Women's Health, Women's Lives". Medical Anthropology Quarterly, Sept.1998, Vol.12, No.3, p. 384-390.

Weisbrot, Mark "Structural Adjustment in Haiti", Monthly Review: An Independent Socialist Magazine, Jan. 97, 48(8): 1-8.

White, T. Alastair "Why community participation?: a discussion of the argument", Assignment Children, 1982, vol. No.59/60, p. 17-34.

White, A. 1993. Study on the role of Women in Agriculture, the Socio-Economic Status of Women, and the Status of SCF-Supported "Groupement" and Women's Clubs iin Maissade, Haiti: Study Report. Monograph. Port-au-Prince: Save the Children Federation/Haiti.

Whitehead, Ann, "Failing Women Sustaining Poverty: Gender in Poverty Reduction Strategy Papers", October 9, 2003, London: Christian Aid. On the

World Wide Web at http://www.christian-aid.org.uk/indepth/0306gad/gad_intro.htm

WHO, 1978a. PHC: Report of the International Conference on PHC, Alma-Ata, USSR. Sept. 1978, Geneva: WHO.

WHO, 1978b. Alma-Ata 1978 PHC "Health For All" Series, No.1, Geneva: WHO.

Women's International Network News, "World Population Data Sheet: Maternal Mortality", Summer 97, Vol. 23, Issue 3, p. 21.

Woost, M.D. "Alternatives Vocabularies of Development? 'Community' and 'Participation' in Sri Lanka. In Grillo, R.D., Stirrat, R.L., Discourses of Development: Anthropological Perspectives, 1997, Berg: New York and Oxford.

World Bank, 1984. Haiti: Review of the Impact of Two Development Projects on Women. Notes on Women I Development No. 33. Washington, D.C.: Office of the Advisor on Women in Development.

World Bank, "Haiti / Social Resilience and State Fragility in Haiti – A Country Social Analysis", April 27, 2006, Document of the World Report No: 36069 – HT.

World Bank 1997/ UNDP 1997, "The Living Conditions of the Poor", pp. 1-38.

World Bank / International Monetary Fund (IMF), 1999a. "Poverty Reduction Strategy Papers-Operational Issues". Draft for discussion. (http://poverty.worldbank.org/files/operational_issues.pdf).

World Bank 2000. "Poverty Reduction Strategy Paper – Internal Guidance Note" (http://www.worldbank.org/poverty/strategies/intguid.pdf)

World Bank 2001a "Poverty Reduction Strategy Papers Source-book" Preface, Draft for Comments. (http://www.worldbank.org/poverty/strategies/chapters/preface/pref0618.pdf)

World Bank 2001b "Grouping of HIPCs under the enhanced HIPC initiative: status as of December 2001" (http://www.worldbank.org/hipc/progress-to-date/Grouping-December.pdf)

World Bank. 2001. World Development Report 2000/2001. New York: Oxford University Press.

World Bank, 2004, "Haiti Country Overview", pp.1-6. Accessed from Website at http://web.worldbank,org/WBSITE/EXTERNAL/COUNTRIES/LACEXT/HAITI...

World Development Report 1994, World Bank, Washington, DC, 1994.

World Development Indicator, World Bank, 1999, pp. 96-112

World Health Organization (WHO), "World Heath Day 1998: Improve Access to Maternal Health Services (WHD 98.7)". Accessed online at www.who.int/archives/whday/en/pages1998/whd98_07.html

World Health Organization, 1989. Coverage of Maternal Care: A Tabulation of Available Information, 2nd Edition. WHO/FHE/89.2. Geneva. World Health Organization, Geneva.

WHO/UNFPA/UNICEF/World Bank Statement (1999). Reduction of maternal mortality, Geneva: World Health Organization, pp.5-31

Zakus, J.L. David and Lysack L. Catherine, "Revisiting Community Participation" Health Policy and Planning, review article, 1998, 13(1): 1-12.