The Need for Midwifery Clinics in Rural Haiti:

Maternal Health in Rural Haiti

Morgan V.

12/1/2019

Haiti is one of the most impoverished countries in the world and the poorest country in the Western Hemisphere (World Bank, 2019). Unsurprisingly, their quality of health care, and even more so, their maternity health care, is inadequate; although Haiti has slowly been making progress over the last few decades, it still has the highest maternal mortality rate in the Western Hemisphere at 359 deaths per 100,000 live births (World Health Organization, 2015) and a neonatal mortality rate that is higher than the international average (World Bank, 2018). For rural Haitian women to have good, holistic antepartum, intrapartum, and postpartum care is uncommon, not because they do not require it, but because for most women, it simply isn't an option. Medical care is unaffordable for the average Haitian, who only makes around $868USD per year (World Bank, 2018), and clinics are often inaccessible, even if the cost of care can be afforded.

Factors that influence the inaccessibility of medical care are that Haiti is underdeveloped, impoverished, and constantly in the path of both natural disasters and corruption. Currently, there is civil unrest in Haiti over the state of its government and there has been for quite a while; rioting has almost become a national past-time. The citizens have good reason to resist their government too, as their country ranks at 161/180 on the Corruption Perceptions Index because of the internal greed and the fight for control happening between government officials (Transparency International, 2018). In addition to this, natural disasters, such as earthquakes, hurricanes, and floods, consistently wreak havoc on this Caribbean nation, which seems never to fully recover. This is partially due to the absence of a healthy government,

which, if present, could organize effective restoration. Poverty is another factor which could be argued as also being a result of a corrupt government. These issues only aggravate the already fragile health care system, set progression back further and further, and cause outbreaks of fatal diseases.

The health care system in Haiti, which is run by the Ministry of Public Health and Population (MSPP), was further devastated beyond its normal level of disrepair when the 2010 earthquake occurred, demolishing 50 health centers, part of its primary teaching hospital, and the Ministry of Public Health and Population building (USAID, 2017). This catastrophic earthquake also destroyed the structural foundation of the nation's only midwifery school, leaving it unavailable for use and stalling the work of educating more, much needed midwifery students. The earthquake and subsequent natural disasters and diseases, such as the cholera outbreak in October of the same year, have made it difficult for the MSPP to make much progress. These disasters, combined with government corruption and instability, have all played a role in promoting the absence of adequate health care, especially for rural citizens. Due in part to these issues, there are only a few rural health clinics that are currently operating in Haiti, and those that are, lack supplies and resources to provide the best care possible.

Inaccessibility plays a large role; the majority of medical care facilities are in urban and metropolitan areas, making it nearly impossible for rural women to receive the medical care they need. While there are a few rural clinics where the average travel distance may not be far, getting there could be impossible. With mountains and rocky, uneven roads all being a part of the rural Haitian landscape, it is not safe or achievable to walk on foot to the nearest clinic, especially for

a pregnant woman. This factor, combined with the lack of transportation, either personal or public, often makes it easier, and even safer, to stay home. The inability to access medical care facilities creates an additional problem for pregnant women, as medical conditions that would be easily treated are exacerbated by pregnancy. Lack of access to medical care to treat these conditions combined with the lack of continuous prenatal care and delivery without the presence of a skilled birth attendant, make it understandable, and tragic, that pregnancy outcomes in Haiti are often very poor. Independent midwifery clinics face these same obstacles with women they intend to care for, in addition to some unique issues; one of them being the lack of access to not just clinics, but also midwives themselves.

The United Nations has recognized that there is a severe shortage of midwives in Haiti and have calculated that approximately 10% of midwifery needs in Haiti are currently being met (United Nations Population Fund, 2019). In 2010, only one quarter of pregnant Haitian women had an institutional delivery, with the majority of these births occurring in urban areas (Séraphin, Ngnie-Teta, Ayoya, Khan, Striley, Boldon, Mamadoultaibou, Saint-Fleur, Koo, Clermont, 2014). Women in rural Haiti are further away from most health care clinics, so only a quarter of them delivered their babies in a health care facility, while about 60% of urban women delivered in a health care facility (Wang, Winner, Burgert-Brucker, 2017). This lack of seeking care originates from multiple factors such as financial instability, distance of the midwifery clinic from the women's' homes, the level of care provided and the mistrust in care providers and the medical model.

Financial instability is a common reason that rural families worldwide do not seek medical care. The MSPP is a system that requires direct payment at point of delivery, which causes a financial barrier, especially for rural citizens. Although the MSPP policy focuses on equity, solidarity, and social justice, since compliance to these values requires the introduction of universal health care, it still remains a distant prospect (Alfred, 2012). In many countries, including Haiti, hospitals and health clinics will hold a mother hostage until the care provided to her is compensated for. This can keep rural families from seeking care when it is needed most, such as when there are signs of a possible complication or emergency, because they cannot afford to pay for care or lose the woman to being held hostage at the health care facility.

Another factor is access; health facilities are typically in metropolitan areas in Haiti and while 99% of women in these areas have access to two or more health clinics, about one-fifth (18%) of rural women have access to these facilities (Wang, Winner, Burgert-Brucker, 2017). Even if a health clinic is in close proximity to a pregnant woman, she will often choose not to make the journey there because she most likely does not have a form of transportation and the road conditions are treacherous. Walking on foot, especially if she is in labor or even just pregnant, would be miserable and dangerous because the terrain is rocky and mountainous. While health care providers mean well, rural Haitians delay seeking their help because they are unfamiliar with the practices of modern medicine and would rather go to a traditional healer for assistance, according to their culture and religion. Modern medicine practices are considerably a mystery to rural Haitians, partially because of the lack of health clinics who provide it.

An additional factor is the mistrust of health care workers. Health care workers from currently operating clinics have found it hard to gain the trust of the citizens. Much of this distrust comes from the Haitian culture, which is based on their specific interpretation of the religion of Vodou, which encourages the use of traditional healers and self-diagnosing and healing. People are also skeptical about modern medicine because they are not familiar with its use and so they would rather go to a traditional healer for assistance; this is further complicated by the inaccessibility to a health facility that uses such medicine. While health care workers mean well, it is especially hard to reach and care for women because health care in their culture starts with self-healing before they consider seeking medical help. On the surface, Haiti is known as a Catholic country, as far as religion goes, but underneath that religious covering, the majority of the people practice the Vodou religion. Haitian Vodou is called a "spirit religion" because the people directly praise, talk to, and become possessed by the spirits instead of directly with God. Religion plays a role in the way women are viewed in a community and in this religion, women are respected and considered the center of society. Women can be priests of this religion, called mambos, and lead their community in religious activities.

While women are respected in their religion and have equal political and civil rights in their country (Const. of the Republic of Haiti, Title III Art. 17), in one case study of 200 pregnant women, 77.8% reported that they had been sexually violated by their partner (Small, Gupta, Fredric, Joseph, Theodore, Kershaw, 2008). Additionally, sexual violence against women and girls increases dramatically when there is a natural disaster and they are left vulnerable in dangerous situations as seen in a study of women in Cité Soleil, where a sexual violence epidemic

was occasioned by the 2010 earthquake, and over half of the female citizens were reported as being victims of sexual violence (Rahill, Joshi, Lescano, Holbert, 2015). The 2010 earthquake left more than just death and devastation, it also left women and girls vulnerable to becoming sexually manipulated and abused. Sexual violence against women is prevalent and unrestrained in Haiti, more so than gender inequality, which makes the implementation of the continuity of care model that midwives provide crucial to women's health. If this model of care was implemented, rural women could regularly be cared for and observed to detect any abuse that they may be enduring; and to find ways to keep them and their babies as healthy and safe as possible during their pregnancy and continuing on into the rest of their lives.

Midwives are vital to the development of health care in Haiti as they are able to provide continuous care and support to expectant mothers and build and strengthen the community they work in. The United Nations has recognized that skilled midwives can prevent approximately two-thirds of maternal and neonatal deaths that occur due to preventable diseases or complications (United Nations, 2014). Midwives not only provide exceptional care, but they can also provide invaluable education about reproduction, family planning, hygiene, and nutrition to women and ultimately save lives through their work and knowledge. They can also educate willing traditional Haitian birth attendants, called matwóns, about the importance of cleanliness in the birth room and how to identify signs of pregnancy and birth conditions and complications. The majority of births in rural Haiti are attended by these traditional birth attendants. However, if they were educated by midwives and integrated what they learned into their practices, we could see a significant drop in the mortality rates of both mothers and neonates.

The midwifery model of care, which is the continuity of care model, focuses on the overall well-being of the mother and baby in the prenatal, intranatal, and postnatal phases. This is considered holistic care, which focuses on the body, mind, spirit, and emotions of every woman cared for and individualizes this care to each woman. This holistic approach to health care allows for relationships to be formed between the midwife and the woman and her family. This relationship is personal yet professional, allowing for a trusting and friendly connection between the midwife and the mother, which, long term, affects the community as a whole. It is also known that a more holistic approach to health care decreases the likelihood of diseases or illnesses because of the continuous care that this model utilizes. Midwives attend to mothers and babies, but they can also do much more; they can teach classes on childbirth education, female well-being, parenting, family planning, and nutrition, creating a space where a community of women can come together and become educated and empowered by their new knowledge.

An organization that is currently implementing the midwifery model of care effectively is Midwives for Haiti. Midwives for Haiti is a not-for-profit organization that is partnered with the country's Ministry of Public Health and Population. This organization strives to provide easy access to care, quality of care to pregnant women, and educates nurses to become skilled birth attendants. In addition to this, Midwives for Haiti has a traveling clinic that serves 22 rural villages across the central plateau of Haiti. This mobile clinic employs four full-time and two part-time Haitian women to provide care for rural pregnant women who have universally expressed a positive view and satisfactory experience with this model of care (Hosler, Abrams, Godsay, 2018). The organization's main goals are to reduce Haiti's unacceptable maternal and

infant mortality rates through midwifery care and to provide education to skilled birth attendants, traditional birth attendants and pregnant women.

The solution proposed herein for the lack of maternal health care services in rural Haiti is the use of multi-purpose, not-for-profit, independent maternity clinics in rural villages across the country. These clinics would be Christian-based, and they would function accordingly. They would be run by experienced midwives, possibly American CPMs (Certified Professional Midwives) or women of similar education and experience, that would follow the midwifery model of care and provide holistic health care for the expecting mothers of the community. However, going into a village where there is little to no access to medical care would mean that the maternity clinic would need to have personnel that knew basic medicine for when an emergency arose. This person could be a nurse or even a doctor; it would be important to have one such provider on staff, as the community would probably expect to have some kind of general medical care included in the center. This would not take away from the main purpose of the clinic, however, it would just be an addition to it until a proper medical clinic is opened or the government decides to fix the roads. This maternity clinic would include prenatal and well woman appointment rooms, an ultrasound room, delivery rooms and a community garden. It would also provide living spaces for the staff apart from the main building. The main vision of this clinic would be to care for the women of the village as well as start to heal and build up the community.

Services that would be provided are antepartum, intrapartum, and postpartum care along with well-woman check-ups. A study has found that if a clinic provides easy access to antenatal

care it could greatly increase the rate of institutional delivery (Séraphin, Ngnie-Teta, Ayoya, Khan, Striley, Boldon, Mamadoultaibou, Saint-Fleur, Koo, Clermont, 2014). To help build community and knowledge of women's health, this clinic model would provide frequent, educational classes for women on childbirth, parenting, natural family planning, the female reproductive system, nutrition, and hygiene. It would also provide classes for the community on how to care for and sustain a garden to grow their own food and how to use their native herbs for healing.

The clinic would employ a number of locals to serve as ambulance drivers, farm workers, security, housekeeping, midwives, and birth attendants. The clinic's main focuses would be on the health of the mothers, the health of the children and the development of a strong community. Rather than condemn the matwóns because of their traditional ways, this clinic would work with them to care for the community's pregnant women and educate them on warning signs of serious complications and conditions of pregnancy and birth, as well as the importance of cleanliness when attending a birth. It would be the intent of this community maternity clinic to be just that- community. Staff would sign a commitment contract of at least six years to ensure that community comes first and that there is rest for the staff member in the seventh year, a year to be with the Lord, as was commanded of Moses and the people of Israel (The Holy Bible NIV, Levi. 25.4), if they desire it. However, this clinic would not be opposed to short-term missions teams, rather, they would be readily welcomed, as extra help will always be needed. When a woman and her family are unable to provide compensation for medical care, which is expected of the majority, the clinic would provide other means of payment such as

working in the community garden, trade, or helping with cleaning and maintenance of the clinic. No woman should be denied maternal care and so the clinic would find a way to be properly compensated, that both the clinic and the woman agree on, for their care of her.

This clinic model is largely taken from The Farm in Summertown, Tennessee that Ina May Gaskin, "the mother of authentic midwifery", and her husband, Stephen, started back in 1971. While The Farm is focused on the preservation of the earth and maternal health care, they do not acknowledge that God created both the earth and the woman and needs to be a part of their care. The people of The Farm are intentional about community; however, they are more of a commune, which is not what is trying to be replicated in the proposed model. The Farm seamlessly combines healing and caring for the earth with holistic midwifery yet, it is not done in the exact way that is being proposed here. The proposed clinic model is one where, yes, the people will live in community, but they will have their own, separate houses and farms to care for. This will allow for the responsibility of each family to care for themselves yet, it will also provide accountability and assistance from a close-knit community whenever there is a need. The proposed clinic will allow for a holistic approach to childbirth, but it will also provide a few more options than The Farm does, as far as medical interventions go, because of the difficulty of getting to a hospital. Lastly, the proposed clinic will be centered around God and rely on Him for provision rather than relying solely on the earth.

When compared to Midwives for Haiti, this model is slightly different yet, in part, modeled after Midwives for Haiti, too. They both implement the midwifery model of care and focus on education, as well as maternal health and the proposed model would eventually

implement the use of mobile clinics for reaching nearby villages. The proposed clinic would also implement similar teaching methods used to teach the matwóns that Midwives for Haiti uses. However, the proposed model also focuses on community development and enrichment through farming and education. Midwives for Haiti works with the MSPP in St. Therese Hospital and educates nurses to become skilled birth attendants. While these are important causes to be working for, they are not the focus of the proposed clinic, which will operate out of its own building in a rural village. Training up skilled birth attendants is important, and this model would encourage it; however, it will most likely not have the capacity to undertake training them. Sending women to be trained as midwives would be something that the clinic would enthusiastically encourage. One of the goals of the clinics would be to partner with Midwives for Haiti and other maternity clinics to combine resources and help each other, such as the proposed clinic sending women to another clinic that provides birth attendant education for Haitian women. In the same way, Midwives for Haiti could send some of their graduates from their skilled birth attendants class to work at this clinic.

In conclusion, even though the maternal mortality rate and lack of maternal health care is tragically high in Haiti, small improvements are slowly being made to improve the health care system and the care that is provided for women all across the country. While the end of these improvements does not seem to be in sight, the opening of independent, community-driven maternity clinics in rural areas could greatly reduce the maternal and infant mortality rates by providing holistic, continuity of care, as well as providing education for the entire community on sustainable living. In addition, the inaccessibility to medical care, for the reasons previously

stated, would not be of great importance when this maternity clinic model, which focuses on providing quality care at whatever price can be afforded by the woman and her family, is implemented into several rural areas. Maternal health is currently one of the most significant issues in Haiti, but by implementing this maternity clinic model, we could see great improvement over the next decade. The improvement of maternal health is vital to the building up and restoring of Haiti as Haitian mothers are influential on the next generation and how they think and act. No child should grow up and go through life without his mother and no woman should suffer when giving birth to her child: this is why maternal health in rural Haiti needs immediate attention and a remedying solution.

Works Cited:

Alfred, Jean-Patrick. "What Is the Real Cost of Universal Health Care in Haiti?" *Sante Publique (Vandoeuvre-Les-Nancy, France)*, U.S. National Library of Medicine, 2012, www.ncbi.nlm.nih.gov/pubmed/23472986.

Constitution of the Republic of Haiti. Title III. Article 17.

The Holy Bible. *New International Version.*

Hosler, Jennifer J.F., et al., "Combining Task Shifting and Community-Based Care to Improve Maternal Health: Practical Approaches and Patient Perceptions." *Researchgate.net*, Sept. 2018, www.researchgate.net/publication/327685250_Combining_task_shifting_and_communit

y-based_care_to_improve_maternal_health_Practical_approaches_and_patient_perceptions.

Rahill, Guitele J., et al. "Symptoms of PTSD in a Sample of Female Victims of Sexual Violence in Post-Earthquake Haiti." *Journal of Affective Disorders*, Elsevier, 11 Nov. 2014, www.sciencedirect.com/science/article/abs/pii/S0165032714007009.

Transparency International. "Corruption Perceptions Index 2018." *Www.transparency.org*, 2018, www.transparency.org/cpi2018.

Séraphin, Marie Nancy, et al. "Determinants of Institutional Delivery Among Women of Childbearing Age in Rural Haiti." *SpringerLink*, Springer US, 25 Nov. 2014, https://link.springer.com/article/10.1007/s10995-014-1646-1

Small, Maria J., et al. "Intimate Partner and Nonpartner Violence against Pregnant Women in Rural Haiti." *International Journal of Gynecology & Obstetrics*, No Longer Published by Elsevier, 1 Aug. 2008, www.sciencedirect.com/science/article/abs/pii/S0020729208002385.

United Nations. "Midwives Can Prevent Two-Thirds of Deaths among Women and Newborns – UN Report | UN News." *United Nations*, United Nations, 3 June 2014, https://news.un.org/en/story/2014/06/469852

United Nations Population Fund. "Midwifery Dashboard." *United Nations Population Fund*, 2019, www.unfpa.org/data/dashboard/midwifery.

USAID. “USAID Health Infrastructure Fact Sheet.” *USAID*, 2017, www.usaid.gov/sites/default/files/documents/1862/FINAL_HealthInfrastructure_March_2017.pdf.

Wang, Wenjuan, et al. “Limited Service Availability, Readiness, and Use of Facility-Based Delivery Care in Haiti: A Study Linking Health Facility Data and Population Data.” *Global Health, Science and Practice*, Global Health: Science and Practice, 27 June 2017, www.ncbi.nlm.nih.gov/pubmed/28539502.

World Bank Group. “GDP per Capita (Current US$) - Haiti.” *Data*, 2018, https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=HT.

World Bank Group. “Mortality Rate, Neonatal (per 1,000 Live Births) - Haiti.” *Data*, 2018, https://data.worldbank.org/indicator/SH.DYN.NMRT?locations=HT.

World Bank Group. “Overview.” *World Bank*, 2019,www.worldbank.org/en/country/haiti/overview.

The World Health Organization. “Maternal Mortality in 1990-2015.” *WHO*, 2015, www.who.int/gho/maternal_health/countries/hti.pdf?ua=1.