



Making Sense of a Fragmented Health System the Health-Seeking Journey of Poor Urban Haitian Women With a Short- Term Insurance in Port-Au-Prince, Haiti a Mixed-Methods Study

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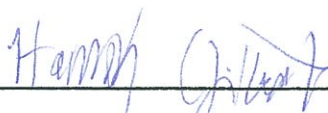
This Thesis, Accessing Health Care in a Fragmented Health System: A Mixed Methods Study in Urban Haiti presented by Phenide Beaussejour and Submitted to the Faculty of The Harvard Medical School in Partial Fulfillment of the Requirements for the Master of Medical Sciences in Global Health Delivery in the Department of Global Health and Social Medicine has been read and approved by:



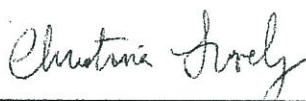
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ACCESSING CARE IN A FRAGMENTED HEALTH SYSTEM:
A MIXED METHODS STUDY OF SHORT-TERM HEALTH INSURANCE IN
URBAN HAITI

PHENIDE ANGE BEAUSSEJOUR, M.D.

A Thesis Submitted to the Faculty of

The Harvard Medical School

in Partial Fulfillment of the Requirements

for the Degree of Master of Medical Sciences in Global Health Delivery

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Accessing Care in a Fragmented Health System:
A Mixed Methods Study of Short-term Health Insurance in Urban Haiti

Abstract

The Haitian health system relies on an out-of-pocket payment system sustained by two main actors: the international community and households, at 52% and 32% respectively (MSPP, 2015). Financial barriers constitute one of the main issues in access to health care in Haiti, where only 4% of the population has health insurance. Therefore, there is a need for alternative payment options to increase access for the poor.

This study explored the experience of poor women former camp residents in Port-au-Prince, Haiti, enrolled in a subsidized health insurance plan. We used a convergent mixed-methods design. The quantitative component of the study evaluated the use of the insurance and the reported impact on health expenses. The qualitative component examined the factors that influenced the use of insurance, and identified beneficiaries' perspectives and experiences with the program. Quantitative data were collected through a survey (n=64). For qualitative data semi-structured interviews (n=30) and participant observations (n=3) were performed.

The quantitative data revealed an increase in hospital visits with the insurance and reduced expenses for the services that were included in the package. However, the data indicated that the insurance package was insufficient since certain types of care were not covered. This presented as a fundamental limitation of the program. Four major qualitative findings emerged: insurance conferred a sense of "membership" to a larger citizenship; the women's reception at the clinic was important as it translated into access to care; the health insurance was as

fragmented as Haiti's health system; despite the shortcomings of the health insurance, the women found the health insurance useful.

This study highlights the importance of a meaningful insurance package, informed by people's realities, to ensure adequate access to care. The research also demonstrates the potential that insurance has in reviving an essential component of the social contract between the Haitian state and its citizens. The field of health insurance emerges from our study as a potent arena for the Haitian state to reclaim its role in providing for the health of its people. Therefore, the state and international partners have to coordinate their efforts to build public safety nets to promote improved health outcomes.

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1. Introduction

Despite significant progress in health technologies and treatment, important disparities in access to care exist globally and these disproportionately affect communities in low and middle-income countries. One of the major issues affecting equal access to health care is out-of-pocket health expenditure, or “direct payment.” Direct payment affects both access to care and health outcomes (Lee & Shaw, 2014). A 2010 World Health Organization report notes that universal health coverage is hampered by a reliance on direct payment. WHO director, Margaret Chan, refers to direct payment as “by far the greatest obstacle to progress” (WHO, 2010). This leads to complications related to late consultations, high mortality and morbidity rates, and a high burden of preventable diseases and deaths. Direct payment also causes financial hardship, especially for poor populations (WHO, 2010), which aggravates their socio-economic condition and creates room for future health issues.

In Haiti, the health system faces enormous challenges, with only 60% of the population having geographic access to basic health care (MSPP, 2012a, 2012b). The country is home to the worst health outcomes in the region, claiming the region’s lowest life expectancy rates, and highest rates of maternal death and under-five mortality (World Bank, 2015). Even within the country, notable disparities in access to care exist between the rich and poor. For instance, the richest quintile accounts for 78.2% of institutional delivery costs compared to 5.9% in the poorest quintile (MSPP, 2010). The Haitian health system relies almost exclusively on an out-of-pocket, direct payment model. Between 2011 and 2013, Haiti saw a drop in international health funding. To make up for this gap, Haitian households have seen an increase in their health expenditure from 29 % to 32% (MSPP, 2015).

Over the past three decades, several countries, rich and poor alike, have considered health insurance as a solution to improve access to health care and reduce the financial burden of disease among the poor (Spaan et al., 2012; WHO, 2005). Many developing countries, such as Rwanda and Mexico, have achieved important improvements in health care access through the institution of national health insurance schemes (Atun et al., 2015; Spaan et al., 2012). In Haiti, less than 4% of the population has health insurance coverage (MSPP, 2015, p. 7). Moreover, this small minority is covered mainly through private health insurance. The national insurance, “*Office d’Assurance d’Accidents du travail, Maladie et Maternité*” (OFATMA) provides insurance only to public servants.

In an effort to extend health insurance coverage beyond the wealthy minority, some efforts have begun to develop health insurance programs aimed at serving the poor. One of these interventions was designed by the International Organization for Migration (IOM), and was intended to provide subsidized health insurance to the vulnerable populations living within internally displaced camps in Port-au-Prince.

Expanding insurance coverage stands to improve access to health care in Haiti, especially for the country’s poorest populations. To examine the role that health insurance can play in ameliorating access to health care for the poor, this study evaluates the experiences of individuals covered by the IOM health insurance initiative. To better understand these experiences, we conducted a mixed methods study to assess the impact of the IOM’s subsidization of health insurance on health care access among pregnant women in ten (10) IDP camps in Port-au-Prince, Haiti. The quantitative component of the study evaluated the use of the IOM insurance and the reported impact on health expenses. The qualitative component of the study examined the factors that influenced the use of

insurance, and identified beneficiaries' perspectives and experiences with the program.

2. Haiti: background

Haiti geography and population

Situated in the Western hemisphere, Haiti, which means 'highland,' shares the Caribbean island of Hispaniola with the Dominican Republic. Haiti has a population of 10.9 million people (IHSI, 2015) and it is one of the most densely populated countries in the Caribbean, with 307 inhabitants per 27 km² (World Bank, 2014). The country has two official languages, French and Haitian Creole, and one official religion, Roman Catholicism. However, only a small minority of Haitians speaks French and a large segment of the population practices the traditional religion, Vodou, alongside Catholicism and other Christian religions.

Haiti is divided into 10 provinces, 150 communes and 570 sub-communes. In the last two decades the urban growth has risen to 4.7 (MSPP, 2012b). Fleeing poverty in the countryside, a large number of people have migrated to the capital city, Port-au-Prince, where more than 50% of the population live in marginalized areas of extreme poverty (MSPP, 2012b). The rural population still accounts for 52% of the total population (World Bank, 2014). Many of the rural people are dispersed in remote areas, isolated from the rest of the country by lack of roads and basic services. In addition to the demographic challenges, Haiti also faces severe environmental degradation caused by massive deforestation, soil erosion, poor sanitation, especially in the cities, and frequent natural disasters. This situation has created conditions for an array of health issues (MSPP, 2014).

Poverty in Haiti

Haiti is considered one of the most impoverished countries of the Western Hemisphere. Despite its young labor force, the rich cultural heritage, and its geographical position with great potential for tourism and trade, the Haitian economy is struggling. According to the World Bank, the country per capita gross domestic product (GDP) and human development index (HDI) are among the lowest in Latin America (2015). More than 80% of the population lives under the poverty line of \$1.90 per day, and among those 24% live in extreme poverty (World Bank, 2014). More than 80% of Haitians are unable to meet their basic needs and 24% of them can barely cover their food needs.

Haiti has a high rate of unemployment; the vast majority of the people earn their meager income in the informal sector, relying on their creativity to survive. This Haitian ability to cope with incertitude is very well reflected in the array of names used to describe jobs in the informal sector, such as “*ti degage*,” “*ti demele*” (go without) or “*chomaj degise*” (disguised unemployment).

Access to services is also very low. Only 60% of the population has access to improved sources of water and 26% to improved sanitation facilities (MSPP, 2012a). The rural areas—52% of the population— are the most affected by poverty and have even less access to basic services; 63% of extremely poor households are located in rural areas according to the World Bank (2014).

This skewed distribution of poverty reveals important inequities in Haitian society. The country is plagued by severe inequalities based on gender, class, and geographical location. The gap between the richest and the poorest quintiles has increased with the

degradation of the economy. The richest 20% controls more than 64% of the total wealth of the country, whereas the 20% poorest barely held 1% (World Bank, 2015). The schooling rate among 6- to-14- year-olds in non-poor households is 96% compared to a rate of 87% in poor households (World Bank, 2015). Gender inequality also shapes unequal access to employment opportunities, with unemployment rates significantly higher for women (World Bank, 2015).

Decades of political instability and the new world economy have profoundly affected Haiti's economy. Indeed, the consequences have been disastrous for private investment, public development programs and other sectors of the economy, such as agriculture. Trade liberalization policies that were forced on the government by foreign donors in the early 1980s, combined with frequent natural disasters and severe environmental degradation, contributed to the collapse of Haiti's agriculture sector. Food insecurity remains a significant issue for the Haitian people, with 38% of the population identified as "food insecure" (WFP, 2013).

The Haitian Health System

a. Health care services

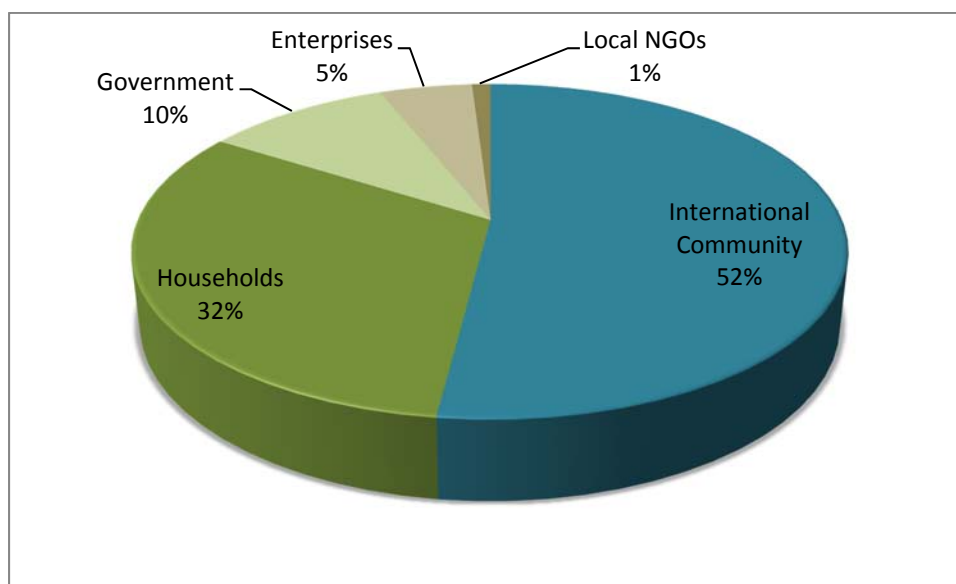
The Haitian health care system consists of two sectors: the public and the private. Depending on the standard of services, health facilities are classified into primary, secondary and tertiary levels, with the latter generally offering the greatest variety of services. As of 2013, the health system counted 1048 health facilities: 12% are hospitals, 14% are dispensaries with beds and 74% are dispensaries without beds— the latter only provide ambulatory care (MSPP, 2015). The private sector, which is divided between profit and non-profit institutions, accounts for 46.1%. However, for 70% of the population the first resort in

case of medical needs is traditional medicine (MSPP, 2012b), commonly called “*Medesin Fey*.” This sector comprises traditional healers, traditional midwives and vodou priests “*hougan, manbo*” who play several roles ranging from doctor to psychologist.

b. Health financing

Haiti has an out-of-pocket payment system, which means that people are required to pay upon receipt of health care. Although the state has primary responsibility to provide for the health of the population, its contribution to the national health expenses is very low, only 10%. Two main entities bear the national health expenses: the international community and the household, covering 52% and 32% respectively (MSPP, 2015). The implications of such situation are the high financial burden for the household in a country where the vast majority of people are poor. On the other hand, the high dependence on the international funding is damaging for the leadership of the state. Indeed, the Haitian government has little control over external funding. Most of the external funding is managed by international agencies, including international NGOs, which usually deliver health care in their own facilities. Moreover, because of the large number of international agencies present in Haiti, a significant percentage of this money is used for administrative purposes. As a result, very little money is invested directly into the health system. Furthermore, although the NGOs facilities contribute to facilitating the access to care and also alleviating the health financial burden for the households, they usually structure services vertically around a particular disease, an approach that does not benefit Haiti through health system strengthening. Indeed, in Haiti there are a multiple interventions— mostly concentrated in the capital city— that offer an incomplete package of medical services, with lots of redundancy. As a result, international funding contributes to creating a fragmented health system.

Figure 1: Distribution of Health Funding (CNS 2012-2013)



c. Challenges of the health system

The inequalities that prevail in the Haitian society are also reflected in the health system. The richest quintile accounts for 78.2% of institutional delivery compared to 5.9% in the poorest quintile (MSPP, 2010). There is also a severe inequity in health care coverage, with a large concentration of health facilities in the urban areas.

The health system also faces a severe deficit in human resources. Challenging work conditions are one of the leading drivers of the emigration of Haitian health professionals to other countries, especially the United States and Canada (MSPP, 2010). There is also a local brain drain to international NGOs, which offer better conditions than the public sector. As of 2005, the estimated physician density— the number of physicians per 1,000 population— was 0.4 (WHO, 2016) and in 2010, the estimated total number of health professionals was 6.5 per 10,000 people (MSPP, 2010).

According to the 2013 Haiti Millennium Development Goals report, Haiti has achieved significant improvement in health indicators, especially in maternal and child health (UNDP, 2014). The percent of women having at least one prenatal visit also rose from 68% in 1990 to 90% in 2010 (UNDP, 2014). However, the health situation in Haiti is still alarming, lagging behind most of the countries in the region, including the Dominican Republic and Cuba. Haiti's life expectancy is 62 years old compared to 76 years old in the region (WHO, 2015b). Infectious diseases and malnutrition remain the leading causes of morbidity in Haiti (MSPP, 2012b). Maternal and under-five child mortality, despite significant decline, are among the highest in the region with 157 per 100,000 and 73 per 1,000, respectively, compared to 100 per 100,000 and 28 per 1,000 in the Dominican Republic (MSPP, 2015; WHO, 2015a).

In an effort to support the government goal to reduce the maternal mortality ratio along with the under-five mortality, the Canadian International Development Agency (CIDA) in collaboration with WHO/PAHO, launched the Free Obstetric Care Project (SOG 1) in 2008 (WHO, 2009). The main goal of this project was to offer low-income pregnant women free access to health services. The project was implemented essentially in public facilities and covered the period from 2008 to 2009. The SOG 2, which is an extension of SOG1, followed offering coverage from 2010-2011. This project provided a greater package of services including immunization, nutrition and HIV prevention. The number of health facilities covered also increased from 49 to 63 (WHO, 2011). Finally in September 2011, the project "Manman ak Timoun an Sante" (Maternal and Child Health) was launched with the objective to extend the financial coverage to children under five. This project started in June 2012 and ended in December 2013 and covered a total of 17 public hospitals around the country (Mats

& Jacquet, 2013). At the end of this last project financed by CIDA, the ministry of health has tried to maintain free care access in the main public hospitals in Haiti. However because of financial issues, many public facilities are still struggling to guarantee free access to maternal and child healthcare.

The 2010 Earthquake and the internally displaced

On January 12th 2010, a 7.0 magnitude earthquake struck Haiti, killing more than 230,000 people and leaving more than 300,000 injured profoundly (World Bank, 2016). This disaster seriously affected the infrastructure and population of Haiti, along with other sectors in the country. During the days following the disaster, in several regions of the country particularly concentrated around the capital city, people created new communities: internally displaced camps. By July 2010, more than 1.5 million individuals were living in 1,555 camps, with the largest concentration in the capital (IOM, 2010). The situation in a camp is a crude portrayal of any marginalized neighborhood in the capital. Those camps face challenges such as poor sanitation, absence of basic services, risk of sexual abuses, high rate of violence, among other hazards.

Since the launch of the relocation program by the Haitian government in 2011, the number of camps has diminished dramatically. However, according the International Organization for Migration (IOM), as of March 2016 there were still 62,590 individuals living in camps (IOM, 2016). The vast majority of the relocated population now lives in different slums of the urban area, where services and living conditions are barely different from the camps.

The subsidized IOM health insurance

Established in Haiti since 1994, the International Agency for Migration (IOM) is an inter-governmental organization, which works on issues related to internal and international migration. After the 2010 earthquake, most of IOM activities were directed towards the internally displaced persons (IDP). In the aftermath of the earthquake, there were an estimated 1.5 million displaced persons who were living across more than 1,500 camps; these camps were largely concentrated in the capital city of Port-au-Prince (IOM, 2010). The organization became the lead agency for camp management, emergency shelter, and non-food items distribution.

The IOM health department initiated its activities shortly after the earthquake. The health team consisted of physicians, nurses, psychologists and social workers who worked within the camps. Their main mandate was to facilitate access to health care through a range of activities, such as direct psychosocial support, financial support for health care, and transportation.

In 2011, the Haitian government launched the ‘Relocation’ program, which aimed to provide housing solutions to camp residents so that they could return to their original neighborhoods (IOM, 2012). The program provided each family with unconditional cash transfer of 20,000 Gourdes (330 USD) to pay for a year of rent. An additional 5,000 Gourdes (80 USD) were provided by the IOM so that beneficiaries could start small businesses. IOM was the main partner executing this program. The health team was responsible for ensuring that camp residents would receive the care they needed before leaving the camp.

In 2013, IOM launched the insurance program in an effort to improve access to health care for the most vulnerable IDP groups, especially after the relocation. The targeted groups

included: pregnant women and their dependents, female heads of household and their dependents, all children under five and their families, individuals living with chronic disease and the elderly. IOM subcontracted the provision of the insurance to a local NGO, “*Développement des Activités de Santé en Haiti* (DASH). Founded in 1985, DASH has a network of 18 health facilities including six hospitals, located in in different communes of the capital city with only one located in rural areas.

The insurance premium lasted for a term of six months. IOM paid for all services in advance, permitting insurance beneficiaries access to all DASH facilities. In the first year of the program, DASH offered the premium policy called ‘DASH Plus,’ which provided free access to ambulatory care, basic medicine, and lab tests. This premium had a cost of 300 Gourdes (\$5) per beneficiary. Additional dependents could be added to a policy at the cost of 300 Gourdes (\$5) for an adult and 210 Gourdes (\$3.5) for a minor. In the second year DASH renegotiated the terms of the contract with the IOM, complaining that their institution was facing deficits because of the low price of the insurance premium. The new contract called “*Carte Avantage Santé*” offered the same services as DASH Plus, but the fees paid to DASH by the IOM were raised from \$5USD to \$50 per person covered. In addition, co-pays were introduced, with beneficiaries having to pay 15 Gourdes (\$0.25) per medication and 25 Gourdes (\$0.41) per lab test. In April 2015 IOM put an end to the insurance program because of lack of funding.

3. Methodology

3.1. Study Design

For this research study, we used a convergent mixed methods design. We first

collected quantitative and qualitative data independently and simultaneously. We then analyzed both data sets, comparing the results to look for patterns, corroboration, and contradictions. For the quantitative strand, we conducted a cross-sectional study to evaluate the use of the IOM insurance, and the reported impact on health expenses. In the quantitative component we also explored affordability and socio-structural barriers of the program. In parallel, we conducted semi-structured interviews to capture the beneficiaries' experience. During this qualitative phase, we explored the factors that influenced the use of insurance, assessed perceived impact of the insurance on out-of-pocket expenses, and evaluated the beneficiaries' satisfaction with the health insurance program.

Rationale for mixed methods

We utilized a mixed methods approach to attain a more comprehensive view of the problem through a combination of both quantitative and qualitative methods (Creswell, 2015). While quantitative data can allow study results to be more generalizable, the qualitative piece (interviews and participant observations) gave us the opportunity to gather personal stories and explore individual perspectives in more depth (Creswell, 2015, p. 15). The addition of qualitative methods became even more valuable considering the context of this study, which aimed to advocate for poor people whose voices are often absent from policy discussions. Who better than the individuals who are enrolled in the insurance program to explain their own reality? As Vincanne Adams, professor of medical anthropology, argues: “subjects do matter, and subjects who speak in their own peculiar way and who are embedded in highly mobile social relations particularly matter. In fact it is possible that their testimony should rank more valid than what Randomized Controlled Trials (RCT) tell us” (Adams, 2013).

3.2. Study Setting

The study took place in Port-au-Prince, Haiti. The participants in the study were selected from those who resided in the 50 camps covered by IOM during the health insurance program — from July 2013 to April 2015— within eight (8) communes of the Metropolitan Area of Port-au-Prince, Haiti: Port-au-Prince, Delmas, Petion ville, Tabarre, Port-au-Prince, Cite Soleil, Croix des Bouquets and Carrefour.

3.3. Inclusion and Exclusion Criteria

Inclusion Criteria

In this study, we included adult women who were current or former internally displaced persons in Port au Prince Haiti after the 2010 earthquake, and who also met these criteria:

1. Enrolled as IOM subsidized health insurance beneficiaries
2. Multiparous who had a previous pregnancy in the last 8 years prior to insurance enrollment in 2014
3. Enrolled in the health insurance program as a pregnant woman and who delivered this pregnancy by the time of the study data collection
4. Were 18 years of age or older

Exclusion Criteria

1. Women with zero parity
2. Primiparous women

3. Women whose most recent delivery occurred more than eighteen (18) months before the study start date
4. Women under the age of 18 years

4.4. Study Procedures

For the quantitative component we conducted a cross-sectional study to assess the use of the health insurance package by the beneficiaries and the difference in out-of-pocket health expenditure with and without insurance. We conducted in parallel open-ended semi-structured interviews (qualitative) to capture the beneficiaries' experience. For this qualitative phase, we explored the factors that influenced the use of the health insurance package and also evaluated the beneficiaries' satisfaction with the health insurance. In the quantitative strand, we also included questions on the affordability of health care and socio-structural barriers.

A research team consisted of the local principal investigator (PI), Dr. Beaussejour, and three IOM staff, a nurse, a psychologist and a social worker who conducted the recruitment and the quantitative strand. Dr. Beaussejour conducted all of the qualitative interviews. Prior to the recruitment, the staff received an orientation from the PI and completed the Collaborative Institutional Training Initiative (CITI) on ethical research with human subjects.

Quantitative strand

The quantitative component consisted of a cross-sectional study among women (n=64) who had delivered a baby within eighteen (18) months of the start of the study. During the enrollment phase, the study staff members attempted to reach all of the women

on the list of pregnant women enrolled in the IOM/DASH insurance program in 2013-2014 who had experienced at least two pregnancies. Through an IOM nurse, a psychologist and a social worker, the principal investigator invited all 64 study-eligible pregnant women enrolled in the health insurance program during the period of 2013-2014 to participate. We highlight here that all of the women would have delivered by the time of the study. Overall:

1. 391 women were registered on the list of pregnant women enrolled in IOM health insurance program from 2013 to 2014
2. The research team attempted to contact all 391 women on the complete list
3. 314 women were unreachable
4. 77 women were located
5. 64 women were eligible
6. Zero women declined to participate in the study
7. 64 women participated in the study

Participation rate: 64 over 391 (16%).

The IOM staff contacted each woman by phone to inform her about the study and to invite her to participate in the research. Following the beneficiary's general agreement to participate in the study, Dr. Beaussejour along with the three IOM colleagues carefully read the informed consent form in Haitian Creole. After inquiring about and answering any questions or clarifications from the participant, they obtained her verbal informed consent to participate in the study. The survey was conducted by phone at the most convenient time to the participant.

This cross-sectional study compares the participant experience for the most recent delivery, with health insurance, and previous delivery without health insurance. The survey included socio-demographic information such as age, gender, education level, marital status, and livelihood. The survey also covered information related to the utilization of the insurance package such as the number of prenatal consultations. The last section explored the difference in health expenditure during those two periods.

The survey was conducted in Haitian Creole and the data were recorded on paper by a study investigator. The hard copy contained the participant ID Code, but not her name. The total interview lasted approximately 30 minutes.

Qualitative strand

The qualitative component consists of semi-structured open-ended interviews with a sub-sample of thirty (30) women, purposively selected from the study participants identified in the quantitative component. Those 30 women were selected among the women that were eligible for the study (n = 64). The selection was based on their willingness to share their experience in greater depth. Within this group of thirty women, we conducted participant observations with three (3) women for 2-3 days.

As in the quantitative phase, the thirty women were also contacted by phone by an IOM staff member to invite them to join the study and also confirm a convenient place and time for them for the interview. In instances when the eligible beneficiary declined to participate in this part of study, we invited another person from the quantitative sample.

Dr. Beaussejour conducted all the qualitative interviews in a private space at the participant's home or in a private room at a DASH health facility. Prior to the interview, Dr.

Beaussejour ensured that the participant understood the purpose of the research including what to expect during the interview and the participant observation (for those in the observation group). She read the consent form for and with the participant and answered any questions. Afterwards, the participant was invited to sign the form. All conversations took place in Haitian Creole. Participants with limited literacy were asked to make a mark or a thumbprint. These participants also had the option of having a literate person of their choice being present during the consent procedures.

The in-depth, open-ended, semi-structured interviews lasted up to one hour. We used an interview guide that was translated into Haitian Creole. The interviews were audio recorded; in addition, observations were recorded in the form of notes on paper during the interview. In order to ensure the confidentiality of the data collected during the interview, only the participant's ID code was recorded on both the field notes and the audiotape. The respondents were asked not to use names, but if names were mentioned, these were redacted—and when necessary assigned a code or pseudonym to preserve confidentiality of the data—when the transcript was created. All audio records were destroyed after transcriptions had been verified and a paper back-up copy made. The data were locked in safe filing cabinets and/or stored on an encrypted computer, only accessible to the local principal investigator.

The ethnographic component of the study consisted of in-depth participant observations with three (3) out of the thirty (30) women that completed the in-depth interview. The local PI, Dr. Beaussejour, followed these participants for 2-3 days in their home, workplace and in their path in seeking health care.

The participant-observation consisted of sessions of one to three hours per day for three days. At the beginning of the first session, Dr. Beaussejour reviewed the previous consent form with the participant. During the sessions, the local PI observed the participant in her home as convenient for the participant. During the observations, Dr. Beaussejour asked very few questions, however she encouraged the participant to share her impression and thoughts about the activities being performed. At the end of each session, the local PI had a 30-minute debriefing with the participant to ask questions that emerged from the observations. This debriefing covered the experience of seeking care with and without insurance and how their life conditions shaped this journey.

This ethnographic piece allowed the researcher to get a broader picture of the lived experience of the women in order to provide more contextualization for the study. The local PI used a short ethnographic script to guide the session. This ethnographic script consisted of a reminder of the consent form and an explanation of the observation process to the participant. It also contained a few questions to guide the conversation. These observational data were recorded in systematic notes on a password-protected laptop and/or on paper, which were secured according to the procedures described above.

4.5. Data/Statistical Analysis

The quantitative component included a descriptive analysis of the following for the study population: 1) socio-demographic characteristics; 2) economic factors; 3) enrollment and management of health services; 4) utilization of health insurance; 5) beneficiaries' satisfaction; and 6) health expenditures with and without the IOM insurance plan.

Frequencies were calculated for categorical factors and means, standard deviations, and ranges were estimated for continuous variables.

For the qualitative analysis, we first transcribed all the interviews in Haitian Creole. For the coding process, we also included data from the interviews conducted in the ethnographic piece. Secondly, we created codes using an excel spreadsheet. In order to stay true to the participants' words, we kept the overall transcriptions in Creole for the coding process and selected quotes that were later translated into English. We initially coded seven (7) interviews, based on their richness in details or pertinence to the research question. Then, we created a codebook that was used to code the entire data set of transcripts.

Eight themes emerged through the coding process, which were grouped into relevant and similar codes. Each theme is structured as follows: a label, an explanation of the meaning of the theme and finally an illustration, using one or two quotes from the data. Background was also provided for the eight (8) sections of the qualitative results, as a way to set the stage for each theme. Part of the ethnographic data was used to provide the background that is reflected in the results but also in the discussion section.

4.6. Challenges in the field

Many challenges hampered the fieldwork in Haiti, which officially started on October 26th; one day after the local IRB approved the protocol.

The first challenge occurred with the recruitment process. The study team began making calls as planned, using the phone contact list provided by IOM of women enrolled in the insurance program in 2014. However, most of the beneficiaries were unreachable by phone and there was no address available since the vast majority was no longer living in

camps. After three weeks of calling on a daily basis, only 40 women were reached, among whom only 35 were eligible for the study. Upon the recommendation of the study mentors, we included the group of insurance enrollees from 2013 in order to increase the sample size¹. The team continued with the recruitment until the end of December, reaching a total of 77 participants. Overall, out of 391 women insurance enrollees from 2013-2014, 64 of them were eligible and participated in the study.

In addition, no data on the number and reason for patients' visits could be collected at DASH as was planned, since this information was not available in DASH reports. We could only collect an estimate of those data from the participants.

Finally, the fieldwork coincided with a particularly eventful period in Haiti. Following the elections on October 25, 2015 that proclaimed two presidential victors, including the government's official candidate, thousands of people took over the streets to protest the election results as fraudulent. From the end of October 2015 to February 2016, there was a post-election crisis marked by daily riots mostly in Port-au-Prince and some regions in the countryside. This period also was marked by a rise of insecurity in several zones in Port-au-Prince. Because of the political upheavals, field visits were constantly interrupted as most of the participants live in very challenging areas. As a consequence of those constant interruptions of the field visits, the number of women followed in the

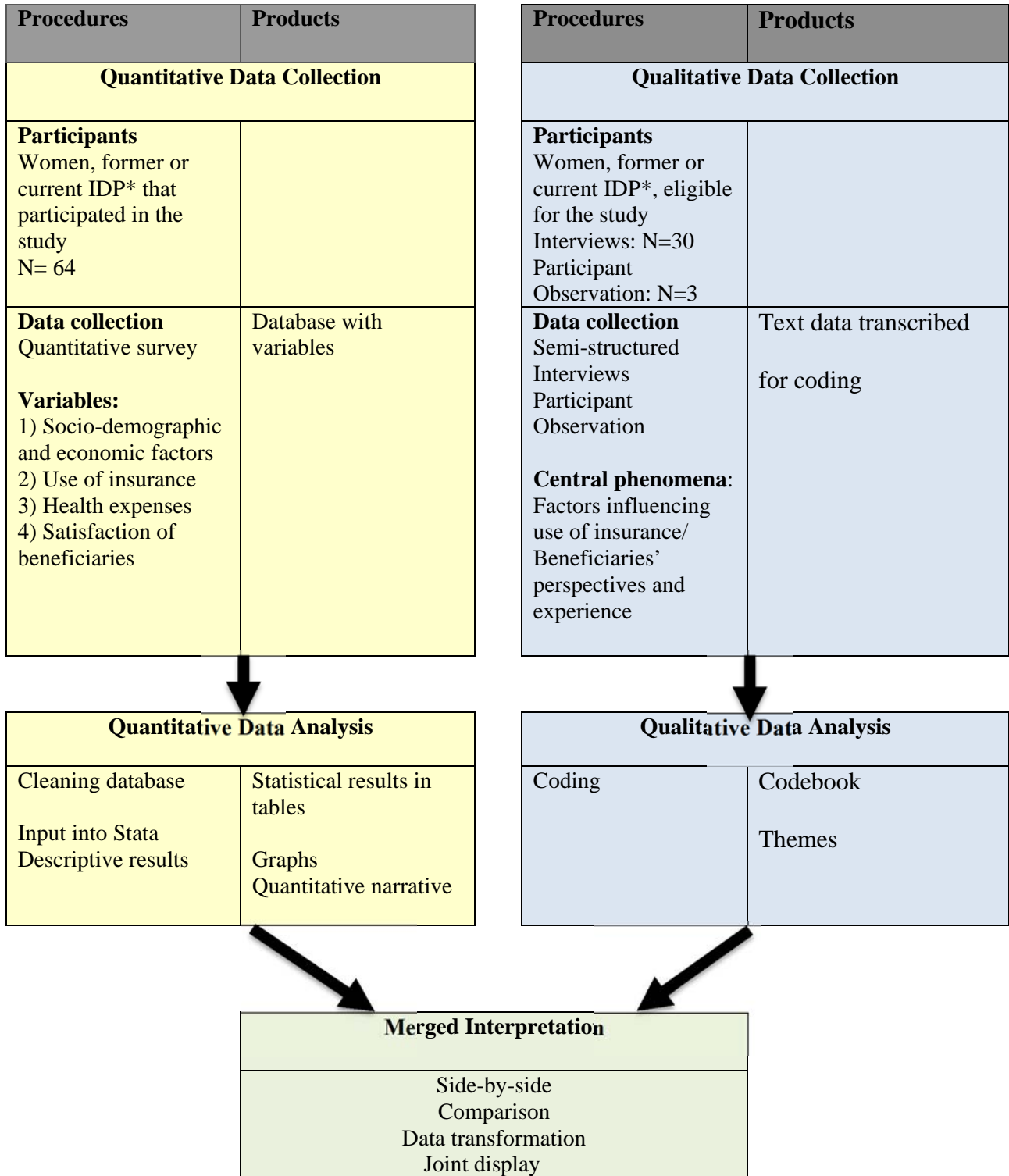
¹ The IRB protocol indicated that we would recruit women currently enrolled in the DASH program in 2014. When we increased sample size, we added people who were currently enrolled in the program during the year 2014 as noted in the IRB protocol, but who had joined the program earlier than January 1, 2014. Since the IRB protocol only noted that women should be enrolled in the program during 2014 and made no mention of when women had enrolled, we did not require an amendment to the IRB protocol.

participant observations was reduced to three as opposed to ten as was initially intended.

The fieldwork ended on February 12, 2016 one month later than originally planned.

Figure 2: The Convergent Mixed Methods Design (Creswell, 2015, p. 59)

Project duration: November 2015 - May 2016



5. Quantitative analysis

Table 1. Social and demographic characteristics of study participants (n=64)

Socio-demographic characteristics	N (%) or Mean (SD) /Range	
Age (n=64)	Mean (SD) 31.6 (5.95)	Range 21-43
Place of Origin	N (%)	
West	20 (31.8)	
Grand' Anse	14 (22.2)	
South East	7 (11.1)	
South	5 (7.9)	
Centre	4 (6.4)	
Artibonite	4 (6.4)	
North West	4 (6.4)	
Nippes	3 (4.8)	
North	2 (3.0)	
Highest level of school completed	N (%)	
No education	3 (4.7)	
Some primary (not completed)	14 (21.9)	
Completed primary school	18 (28)	
Some secondary school (not completed)	27 (42.2)	
Completed secondary school	1 (1.6)	
Some professional training	1 (1.6)	
Completed professional training	0	
Some university	0	
Completed university	0	

Current Marital Status	N (%)
Married	12 (18.8)
Living together	41 (64)
Single	0
Separated	5 (7.8)
Divorced	5 (7.8)
Widowed	1 (1.6)
Housing	N (%)
Own a house	4 (6.3)
Rent a house	44 (68.8)
Live free in another's house	13 (20.2)
Live in a tent	3 (4.7)
Source of income	N (%)
Informal Job	7 (11.0)
Market Merchant	29 (45.3)
Family support	8 (12.5)
No source of income	11 (17.2)
Other	9 (14)
Partner with source of income	N (%)
Yes	42 (68.9)
No	19 (31.1)
Primary family breadwinner	N (%)
Woman	25 (39.7)
Partner	26 (41.2)
Both	9 (14.3)
No one	0

	Other	3 (4.8)
Personal daily income (USD)		N (%)
	\$ < 1 daily	27 (42.0)
	\$ 1- 2 daily	21 (33.0)
	> \$ 2 daily	16 (25.0)
Total number of dependents	Mean (SD)	Range
	4.28 (1.98)	1-10
Total number of children	Mean (SD)	Range
	3.20 (1.76)	1-10

Table 2. Enrollment and management of services by beneficiaries (n=64)*

Enrollment in the Health Insurance		N (%) or Mean (SD) / Range	
Time of pregnancy at enrollment, in months (n=63)	Mean (SD)	6.09 (1.84)	Range 1-9
Reasons for enrollment		N (%)	
	For better quality of care	47 (73.4)	
	Better prices	10 (15.6)	
	Was encouraged to enroll	10 (15.6)	
	Other reason	1 (1.6)	
Management of services not covered by health insurance			
Where participant found services not covered by insurance		N (%)	
	Did not access service	28 (48.3)	
	Paid for them at DASH	6 (10.4)	
	Paid for them in other hospital	18 (31)	
	Found them for free in other hospital	4 (6.9)	
	Used other insurance	3 (5.2)	
Was not assisted at DASH (n=59)		N (%)	
		4 (6.78)	
Reasons for not receiving services at DASH		N (%)	
	Bad reception from DASH staff	1(20)	
	Service not covered by insurance	1 (20)	
	Other reason	2 (40)	

*Sample sizes less than n=64 indicate missing or non-applicable data.

Table 3. Utilization of health insurance (n= 64)*

Utilization of health insurance		N (%) or Mean (SD) / Range	
Number of visits at DASH		N (%)	
	No visit	6 (9.5)	
	One visit	12 (19)	
	2-3 visits	22 (34.9)	
	4-7 visits	18 (28.6)	
	More than 7 visits	5 (7.9)	
Reason for consultation		N (%)	
	Routine Consultation	47 (79.7)	
	Problems with the pregnancy	18 (30.5)	
	Non-maternity associated issues	15 (25.4)	
	Other	3 (5)	
Number of visits per reason (n=55)		Mean (SD)	Range
	Routine Consultation	2.30 (1.63)	0-7
	Problems with the pregnancy	0.61 (1.02)	0-4
	Non-maternity associated issues	0.65 (1.53)	0 - 7
	Other	0.09 (0.67)	0 - 5
Reasons for attending clinic fewer than two times		N (%)	
	Too expensive	3 (11.2)	
	Long distance to facility	2 (7.7)	
	Services not complete	3 (11.5)	
	Bad quality of services	2 (7.7)	
	Long wait time	5 (19.3)	
	Attend other facility	6 (23)	
	Other insurance	2 (7.8)	
	Bad consultation schedule	0	
	Bad reception at DASH	1 (3.7)	
	Other	11 (42.3)	
	No reason	1 (3.9)	
Attend other facility than DASH		N (%)	
		28 (45.9)	
Reason for attending other facility		N (%)	
	Better quality of services	8 (25.8)	
	More services	8 (25.8)	
	More affordable	5 (16.2)	
	Better reception	2 (6.3)	
	Other	18 (58)	
Hospital visit with insurance		N (%)	
	Higher	34 (58.6)	
	Lower	3 (5.2)	
	Unchanged	21 (36.2)	

*Sample sizes less than n= 64 indicate missing or non-applicable data

Table 4. Health expenses with IOM health insurance (n=64)

Cost of procedures with health insurance		N (%)
<i>(These questions asked whether the participant found the costs of procedures listed below either higher, lower or the same when they used the DASH insurance)</i>		
Medical Consultation		N (%)
	Higher	1 (7.2)
	Lower	40 (71.4)
	The same	12 (21.4)
Emergency Care		N (%)
	Higher	0
	Lower	4 (8.9)
	The same	41 (91.1)
Lab Test		N (%)
	Higher	6 (10.7)
	Lower	30 (53.6)
	The same	20 (35.7)
Ultrasound		N (%)
	Higher	6 (11.1)
	Lower	5 (9.3)
	The same	43 (79.6)
Delivery		N (%)
	Higher	0
	Lower	0
	The same	50 (100)

Table 5. Beneficiaries' satisfaction (n=64)

Beneficiaries' satisfaction	N (%)
What participants liked about the insurance	N (%)
Easier to see a doctor	44 (75.9)
Cheaper prices	31 (53.5)
Good quality of services	17 (29.3)
Good Reception	20 (34.5)
Short wait time	15 (25.9)
Other	14 (24.2)
What participants didn't like about the insurance	N (%)
Bad quality of services	1 (1.8)
Service not complete	22 (38.6)
Long wait time	10 (17.5)
Too expensive	3 (5.3)
Bad reception	6 (10.5)
Other	2 (3.5)
Nothing	25 (43.8)
Participants' experience being pregnant with insurance	N (%)
Better	39 (72.2)
Worse	2 (3.7)
The same	13 (24)
Utility of insurance	N (%)
Useful	51 (91)
Not useful	5 (8.9)

Socio-demographic and economic characteristics

We gathered survey data from a total of 64 women, aged 31 years old on average. A high proportion (68.2%) of the study participants lived in rural areas (see table 1). Participants had an intermediate level of education. More than 40% of participants completed a part of secondary school, which is common among those with limited resources in urban Haiti, for whom education is a priority. The predominant marital status among participants was “*plasaj*,” living together, which reflects the prevailing form of union in Haiti.

Our participant population is very poor with 75% of the women living on 0 to 2 USD per day, and within this group, 42% earn less than \$1 a day. Only two women in our study reported daily income of 5 USD per day, which represented the highest daily income of all participants. None of the study participants reported employment in a formal job. Rather, most of them worked as merchants in the market. For the 11% who reported employment in an informal job, the majority worked as servants, and a few others worked in a factory. The rest of the women did not report any income generating activity. These women relied on financial support from their partners, family, or friends. We could further divide the study population into two groups: those who have a stable support from a specific person— her partner or any family members or friends— and the others who receive sporadic support from different and non-stable sources, such as neighbors. This latter “non-stable support” group represents 17.2% of the study participants.

Enrollment and utilization of the health insurance

Data for enrollment and utilization of the health insurance are found in table 2 and table 3 respectively. The primary reported reason for enrolling in the health insurance was to obtain better quality of care. Although the women on average enrolled at a late phase of their pregnancy, 35%

of them made at least two visits at DASH and more than 7% visited the clinic more than seven times. These numbers represent the overall total number of visits, before and after delivery. Women visited the clinic primarily for a routine prenatal consultation. This is a positive outcome, given that in this context financial barriers often prevent people from seeking healthcare services until they encounter complications. Nonetheless, women's reasons for attending were not limited to pregnancy. Consistent with the qualitative findings, many participants also took their children to DASH, as the children were enrolled in the program and their visits were covered in the package. Finally, the main reasons raised for not receiving care at DASH included a poor reception from the DASH staff clinic and the non-inclusion of the specific service in the insurance package (e.g. delivery, emergency care).

Although they had the insurance, many women reported they also visited health facilities other than DASH. Approximately 46% of women reported visiting other health facilities to complete the insufficient package of services provided by DASH and 25.8% indicated that they sought a better quality of services (see table 3). The insufficient package of the DASH insurance affected the beneficiaries in two ways: 1) financially, since 31% of the participants reported that they had to pay for the services not covered by DASH in another hospital; and 2) The incomplete coverage also affected the access to services, especially for the poorest group. Indeed, 48.3% of the women reported that they were unable to access the services that were not covered by DASH because they could not pay for them.

Impact of the health insurance

On the basis of the quantitative data, the health insurance seemed to have an impact on the expenses for the services that were included in the package (see table 4). Under the insurance, women reported paying less for the medical consultation and lab tests, while women reported no change in cost for other expenses such as ultrasound, emergency care and delivery. DASH insurance seemed to increase hospital use, as 58.6% of the women reported a higher frequency of hospital attendance (see table 3).

Beneficiaries' satisfaction

“Easy access to the doctor” appeared as the top reason for satisfaction with the health insurance, followed by “low prices of services.” However, the insufficient package of services covered by the insurance was the main factor of dissatisfaction of the beneficiaries. Nonetheless, the vast majority of the participants — 91% — agreed that the insurance was useful and most of them also reported a better experience with their pregnancy under the insurance program (see table 5).

Figure 3: Highest level of education completed

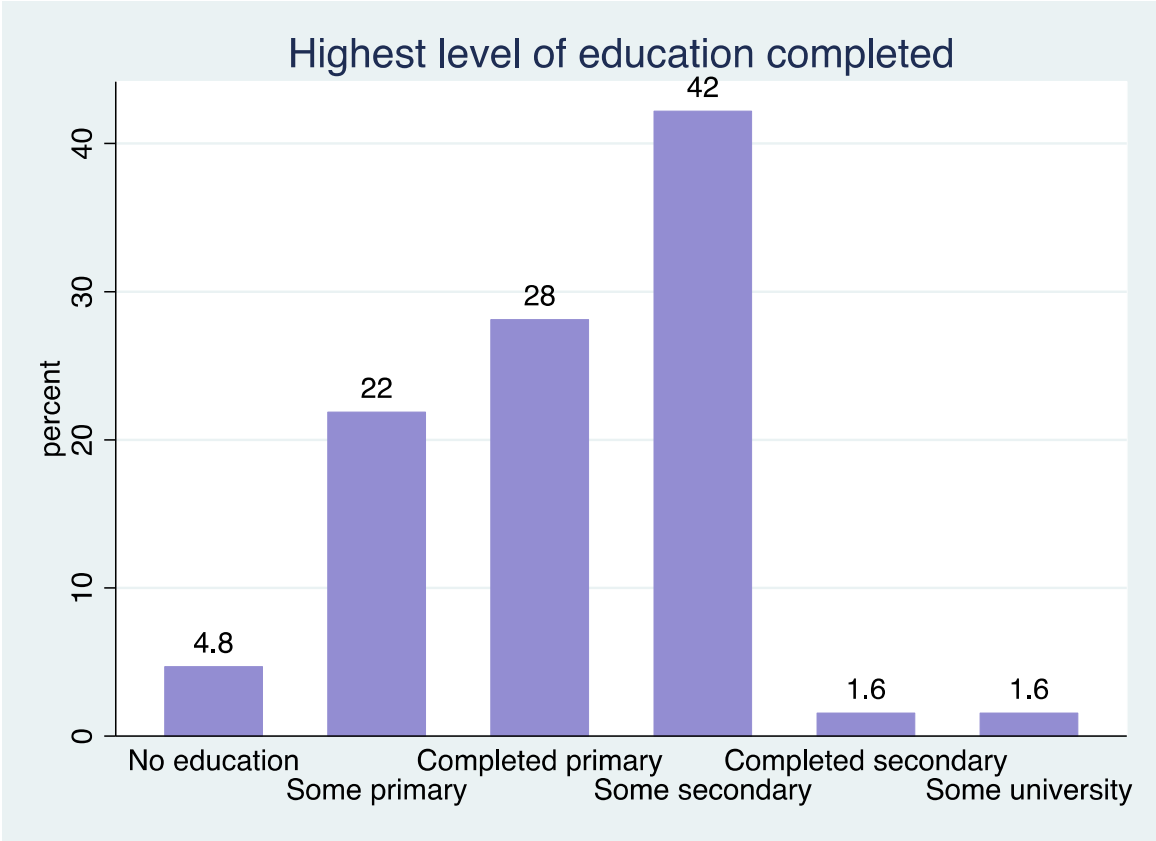
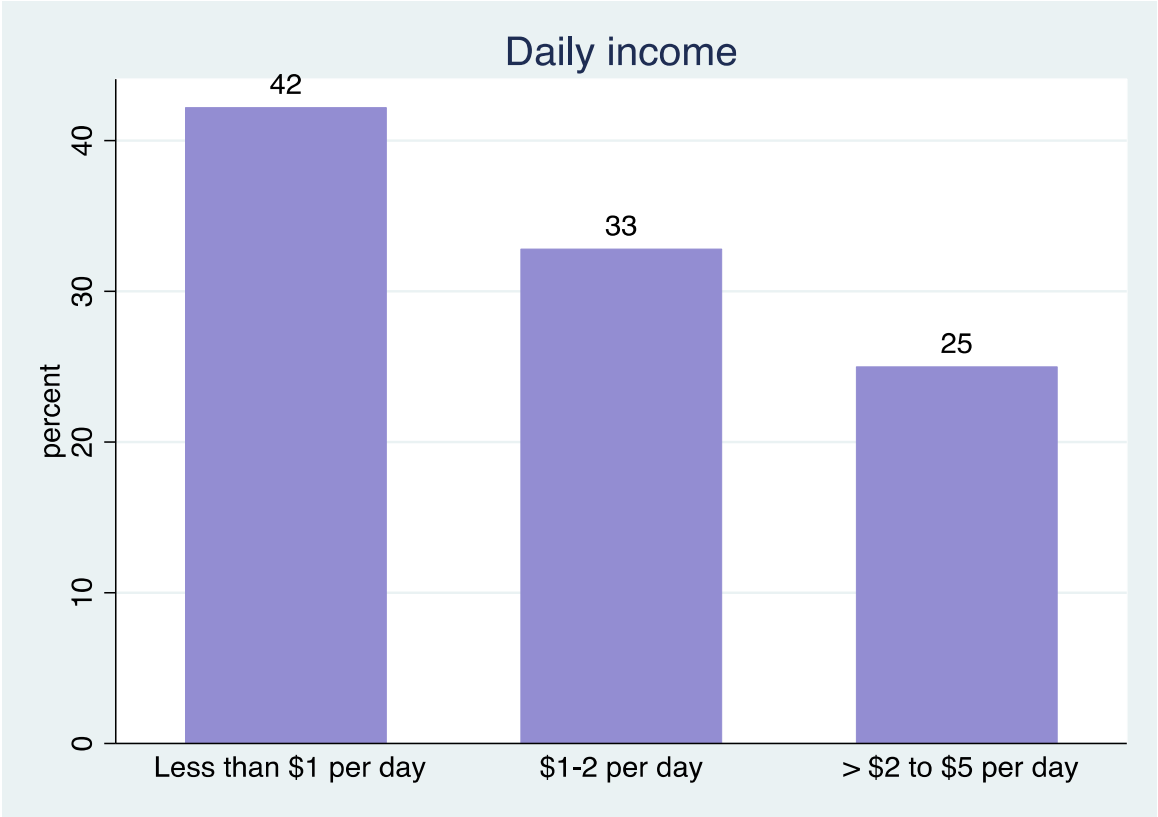


Figure 4: Daily income



6. Qualitative analysis

In this section we report the different themes that emerged from the semi-structured interviews and the participant observations. We close the analysis with the story of one of the women, Darline ².

Social visibility

The IOM insurance beneficiaries represent the most impoverished groups in Haiti. They usually have few possessions they can claim as their own and are denied access to the most basic rights as Haitian citizens, such as access to health care. The vast majority would not have access to health insurance at all, much less insurance with access to a private hospital, because only people with money can pay for private insurance and the state only covers those who have a job. Therefore, participants would describe insurance as *gwo bagay for gwo zouzoun*, which translates to the notion that insurance is a big deal that is reserved for those in the high class.

For the study participants, participation in this insurance was more than a way to access health care; participation gave them a sense of improved social status and belonging to a larger community. Many of the women saw this insurance as an acknowledgment of their own citizenship. One participant even expressed a sense of pride, because with the insurance she could receive good quality care – more so, that she could receive *any care at all* - in a private hospital. To her this insurance meant that she was not stuck with those places reserved for the poor. Instead of being an outsider, she was a part of society. Instead of being invisible and forgotten, she felt

² * All names used are pseudonyms to protect confidentiality of the study participants

that others “saw her” – as a person worthy of care, as a part of society. The following citation illustrates this point:

“This is what I like about the health insurance; I feel like I am part of the society. I feel I exist, that they see me...” **Part. 1, age 38**

Reception matters

With the IOM insurance program giving access to a private hospital to camp residents, the parallel but separate worlds of poor people and the staff of a private hospital, DASH, collide. The vast majority of IOM health insurance beneficiaries represent the extremely poor, lower urban class who have poor access to basic services such as health and education. Because of financial barriers, access to a private hospital is usually impossible for this group, who instead turn to public facilities, NGOs, or institutions of charity for their health needs. DASH medical staff and clients represent a more educated and higher economic class. Accordingly, the encounter between DASH staff and usual clients and the poor women residing in camps is particularly sensitive as it reflects the dynamics of a society characterized by social-class and economic based division and discrimination. Beyond the financial barriers to care, there were also societal barriers such as class-related stigmatization. Those barriers are even more complex because they are subtle. Poor people would feel they do not belong in certain places. In such context, the women I interviewed reported being very sensitive to the way they were received at the DASH clinic.

There was a mixed-experience of the reception at the DASH clinics. Some participants reported a good reception from DASH staff whereas some reported having been poorly received at the clinic.

A welcoming reception can be perceived as a demonstration of acceptance. As one participant described:

“Care was good, because I found a good ‘ti doktè’ (little doctor), who was good to me. He was amiable; he always talked to me kindly, providing me with advice, explaining to me which precautions to take. Yeah, he used to treat me well and the other persons in the clinic always received me very well. I really liked going there.” **Part. 19, age 25**

Conversely, a poor reception was interpreted as the opposite of acceptance. It conveyed a sense of not belonging in this kind of place. Many participants who report having been poorly received by the DASH staff felt as if IOM insurance labeled them automatically as poor and that this label invited humiliation and sometimes discrimination. The following quotes illustrate this point:

“To me, they treat the people who have IOM insurance like nobody. They make you feel like they were giving you a handout. I realized that they (DASH staff) treat people who come with their money better. I felt so humiliated. I got mad and I never came back to the clinic.” **Part. 1, age 38**

As noted above and in the next quote, a poor reception had critical implications for accessing health care, as women who felt unwelcome did not want to return for follow-up care. Even rumors of a poor reception shaped future attendance at the clinic, as noted by the quote below, where the participant describes hearing that people in her community were called names at the clinic. This woman selected a health care provider based on how she felt she would be received, choosing a clinic where she felt she would be known and welcomed.

“I never used the insurance. People in the camp who went to DASH were saying that the staff was looking down on them, calling them camp people. When I heard that I decided that I would never go to DASH. I followed the pregnancy in this clinic, near the camp, run by the nuns. They know me there. They are used to people like us.” **Part. 5, age 33**

Reception goes beyond words. The staff's body language would also affect the patients' perceptions. As the following participant accounted in tears, nurses would look at her with disdain, which to her was directly related to the fact that she is poor. She would express a sense of shame, but she was at the same time revolted because her condition doesn't justify such treatment.

"The nurses there (at the DASH Clinic) have this way to look at me.... I felt ashamed. I did not like that. It's not because I am a 'malerèz' (poor) that you have to look at me like that. I never came back." **Part. 2, age 34**

The certainty of access

For many participants, especially those who experienced a welcoming reception at DASH, insurance meant that you could always access care, even without money. This certainty of "having a place to go" removed the usual "*kalkile*" (rumination) about money when it came to seeking care. Whether they had money or not, they knew if they become sick they can just go to a DASH clinic. The following examples illustrate this point:

"With the insurance I don't have to 'kakile' about money when I need to go to the doctor."
Part. 15, age 43

In a life filled with uncertainty about money, shelter, and food, disease can be cumbersome if not catastrophic. To those women affected, disease can trigger the sense of dealing with all of these problems at the same time. As some participants reported, very often without the insurance they were many times forced to make impossible choices, such as leaving their children hungry to pay for health care for one of them who were sick. As a 44-year-old mother of seven recounted, it is harder to bear disease than to endure hunger. Poor health makes it even more difficult to deal with all their other issues. Therefore, insurance would alleviate the burden of the everyday struggle

by ensuring a certain access to health care. This *gave them a peace of mind*. The following quote illustrates this point:

“The insurance gave me a peace of mind. Because when my children or I are sick it’s not easy. You can bear hunger, but when you’re hungry and you are sick at the same time that can make you crazy. It’s like you have all the problems at the same time .You don’t feel well.” **Part. 3, age 43**

With the insurance many felt they could always go knock on the door, as one would do with a friend or family member. The insurance also protected these women from the feelings of powerlessness caused by financial barriers and the many impossible choices of their day-to-day life. As the following participant noted:

“The insurance was a ‘protection’ for me. Because I know that if I had a problem I had the place to go, to “defann tèt mwen” (get through). No matter what, I could go and knock on the door.” **Part. 25, age 40**

Even so, because of this certainty of access to care women reported that they would seek care earlier. Many participants recounted that, before joining the insurance program, lack of money would prevent them from seeking medical care. They would have tried alternative medicines or waited until “*yo pa kapab ankò*” (the situation gets serious). With insurance, however, whenever they did not feel well, the only thing they had to do was find some money for transportation and go to the clinic. In people’s calculation, it was worth finding transportation money because they were assured access to care when they arrived at the clinic. As this participant described:

“Many times when I was sick I did not have money to go to the doctor, so I used to make ‘remèd fey’ (home remedy) and take pills. But with the insurance, anytime I did feel well I wouldn’t wait and take pills. I would take a ‘tap tap’ (public transport) and go ‘dirèk dirèk’ (straight) to the DASH clinic.” **Part. 28, age 31**

Calculation of cost

The average daily income of the women in the study is 100 Goudes (~\$1.60). Most of these women serve as the sole head of their family, usually without any external financial support, so this meager budget covers all the family expenses, ranging from food to savings for rent and schooling and any other expenses in between. In this hand-to-mouth existence, every penny counts. Therefore, when deciding whether or not to use a commodity, the women calculated not only the direct price of the commodity itself, but also all expenses involved in seeking this commodity. In this complex calculation, even if the health insurance lowered costs, other barriers meant they still could not access health care.

When making decisions about where to seek health services, people in Haiti have different options: private for-profit, private not-for-profit (i.e., NGO and charity clinics) or public facilities. Prices differ from one place to another, ranging from high to completely free. The women in the study made their calculation based on the overall cost of seeking health care. This overall cost encompasses: the price of procedures, the time diverted from their economic activities, the ancillary costs for lab tests and medication, associated benefits such as the inclusion of dependents in the health insurance and finally, the positive impacts of economizing health expenses.

When the IOM insurance launched in 2013, access to consultation, basic medication and lab tests at DASH were totally free for the beneficiaries. However, after the six months of the project, a new co-payment premium was introduced and beneficiaries had to pay a minimum fee for medication and lab tests. This is one factor that explains the mixed experience with prices of procedures at DASH between patients enrolled during these two different policies, without and with co-payment. Women could find alternative clinics to DASH that offered more affordable care, particularly maternity care. Women often took advantage of these choices to find the care

most affordable to them. In general, the perception of prices as low or high shaped the use of insurance.

For some women, prices of procedures with insurance at the DASH clinic were cheaper compared to other clinic where they used to seek care. As they reported, they only had to spend money on transportation. These lower costs encouraged the women to use the insurance, as the following quote illustrates:

“When I have to go to other hospitals, I need money because I have to pay at least 50 Gourdes for the consultation and I also have to pay for the medicine and the lab tests. So I rather go to DASH, because I only need the money for transport and little money for the care.” **Part. 12, age 29**

Conversely, other women found services more expensive at DASH. The women indicated that high prices would prevent them from attending the DASH clinic. As one participant noted:

“When they [the people at DASH] gave me the price for the lab tests, I saw that it was more expensive than where I was following before. So I went back there and stop going to DASH.” **Part. 11, age 39**

Time also has a cost as the women rely a lot on their day-to-day economic activity for survival. Thus, the longer the wait time at the clinic, the more time was diverted from their economic activities, and the more expensive the care was to them. As many report, spending less time at DASH helped them to return to their normal activities and allowed them more time to work to generate critical income. The following quote illustrates how short wait times actually encouraged her to seek care at DASH:

“With DASH, is quick. You spend 2 hours and then you can go back to the market. It’s good for me, because I don’t lose money. This encouraged me to go to the clinic.” **Part. 19, age 25**

Finally, the extension of the insurance benefits to dependents was another factor that caused women to perceive that seeking care at DASH was cheaper than seeking care at other clinics. As is common in Haiti, most of the women in the study are primarily responsible for the health in the family, a responsibility that entails both financial investment and caregiving. Many women reported that one of the reasons for enrolling in the insurance was because their children could also be covered. Indeed, the fact that the insurance not only covers the mother but also the children reduced the total cost of care for those women, as the children's sicknesses usually represented a big part of their total health budget. According to those mothers, they were more motivated to go to the clinic because they would bring their children so they could also see a doctor. This allowed them to save money, especially in large families. This comment of a mother of eight illustrates this point:

"I went very often to DASH because my children were also covered. So I could take them to the clinic with me when I had an appointment or whenever they were sick. This was so much easy and cheaper for me." **Part. 25, age 25**

The above quote also indicates that this one encounter for the family is also more convenient for mothers. They could seek care for themselves at the same time they sought care for their children. That also reduced the amount of time spent away from their economic activities and thus may had a positive impact on their personal finances.

One of the outcomes of the lower cost of care seeking with insurance was that women could reinvest the money saved into other needs, such as food or also saving for the rent. This, as many women reported, was a big motivation for the use of insurance. The following quote illustrates this point:

“With the insurance I could save, because I used to spend less money at DASH than in other places. I would spend 75 Gourdes (~\$1.20) at DASH while I would spend the double in other hospitals. So I can use those 75 Gourdes to do something else.” **Part. 13, age 27**

Incomplete coverage

The IOM health insurance only gave access to the DASH health facilities’ network. Moreover, it covered a limited package of services, including free consultation and minimum fees for basic medications and lab tests available at DASH. Deliveries, surgery, and hospitalization along with other procedures were not covered. In many occasions, as many participants reported, the DASH pharmacy ran low on stock so insurance beneficiaries did not have access to medicines or lab tests. Whether the services were not included in the insurance package or simply were lacking the day of the consultation, beneficiaries had three alternatives. First, they could pay for these costs at DASH at approximately the same prices as the average in private facilities. Secondly, they could seek them in places where they were cheaper or even free. The third option was that the patients would go without the services. Women faced this third option due to non-affordable prices at DASH or other places, if services were not covered or if the women were not able to access information about other places with better prices. Sometimes, the need to invest more time and money in transport to seek the missing service discouraged the women from continuing to seek care options.

Many participants considered the IOM insurance coverage to be incomplete since it did not cover the essentials, the “*gwo mòso*.” The stock-outs worsened the situation and made the beneficiaries question the very meaning of having insurance. As this participant said:

“If you see the doctor but you don’t receive medication then why go to the hospital?” **Part. 5, age 33**

To cover the gap of the insurance services, beneficiaries would often go on a very complex health-seeking journey, which many described as “*monte desan*” (running around). Many women told us how they would have to go to different places to find the services that were lacking in DASH. To many, this process could be very distracting, tiresome and in the end would negatively shape the use of IOM insurance. Indeed, some women would not see any added value from the insurance. They would decide to go to other places, usually the ones they used to visit before the insurance, which often had incomplete services but were closer to their homes, which meant the women paid cheaper transport fees. The following quote illustrates:

“[At DASH], I would usually find only part of the medicines that were prescribed. I would fend for the rest, going to different places. Sometimes I would get tired of this monte desan (running around), so I would go to this clinic close to me where I followed for my previous pregnancy. It’s run by the nuns, it’s not expensive and it’s close” **Part.11, age 39**

Moreover, this limited coverage affects the patient-health care provider relationship. Indeed some women accounted that while they felt certain to receive care at DASH, even without money, this certainty was constrained to the limited services covered by the insurance. When specific health care was not included in the insurance “contract,” a few beneficiaries reported that the DASH staff would change their behavior. They would not assist the patient, who would in turn feel isolated. Some participants expressed a sense of abandonment, like a door that seemed always open would abruptly close. Some participants described how this non-assistance behavior from DASH staff for non-covered services could lead to dangerous outcomes.

A 27 year-old mother of two (2) recounted that 8 months into her pregnancy, despite being diagnosed with preeclampsia, which required emergency care, she was not assisted by DASH staff.

She was told at DASH clinic that she would have to pay at DASH for emergency care or go to another cheaper facility because the insurance did not cover the care she needed. Her husband had to run with her to a public hospital where was able to have a C-section and necessary care for her and her baby. She recounted this episode with some bitterness. She felt that the DASH staff abandoned her.

“I know the big things are not covered by the insurance, but if the doctor at DASH knew that I needed a Cesarean, he should have helped me.”

The quote above also questions the ethical obligation of the medical staff to assist the patient no matter what. This participant indicated while that the insurance brought them closer to the health providers, the incomplete coverage could tear this relationship apart. Health providers who were usually so welcoming would suddenly fail them when the women needed them the most. From this participant’s perspective this incompleteness was also associated with a risk to their health. As she says:

“But I could have died. You could have called and they would have told you ‘li mouri,’ (she died).”

In some cases, this running around was perceived to result in death, as with this 36 year-old mother of four (4), who felt she was forced to deliver her twins at home. At the DASH facility, the staff would not take care of her because delivery was not covered by the insurance. She lost one of the babies during the labor. This mother directly blamed the non-assistance at DASH for the loss of her baby, which also implicated the limited coverage of the insurance. Had the providers at DASH been able to give her the necessary care, she felt the twin would have lived. As her quote illustrates:

“Because they did not attend me at DASH, I was forced to deliver my twins at home and lost one of them.” **Part. 30, age 37**

In her critique of the insurance, she pointed out the fact that the insurance had to cover more services in order to fit the reality of poor people. As she noted:

“There’s something wrong about this insurance. It only covers a few things. They have to put more services. That way the insurance would be more appropriate for ‘malere’ (poor people).”
Part. 30, age 37

Strategic use of benefits

Recognizing the “incompleteness” of the health insurance, women would put together multiple complementary health services options. When making these calculations, the women considered the affordability and availability of the services. Usually, since delivery was not covered and maternity care was cheaper, more complete and more available than non-maternity related health issues, women would seek care for their pregnancy in other centers, “insuring” the delivery. They would save the DASH insurance for other issues. In other cases, they would shop around for complementary services, medication, and lab tests from one clinic to another, putting together pieces of benefits. This is the strategic use of benefits. As the following quotes illustrate:

“Since I was already following the pregnancy in other hospital, I kept going. It was cheap and care was good and they would give you the reference letter for the General hospital for the delivery. I kept the [DASH] insurance for other problems.” **Part. 6, age 29**

“If they give you a urine test in other hospital and you know you have pay, so you would go to DASH and the doctor would prescribe you the urine test and then you get it for free.”
Part. 21, age 30

Geographic incompatibility

The insurance card gave access only to DASH facilities, which were located in the capital city, except for one DASH clinic in the countryside. The vast majority of the insurance

beneficiaries lived in the poorest areas of the capital city while their families still lived in rural areas. When these women wanted to access DASH facilities, two problems emerged: the geographic distance to the clinic and the characteristics of their violent neighborhood that made it impossible to access the clinic even when it was nearby.

Sometimes women moved far away from the DASH clinic because they needed to be with their relatives in the countryside during this important event of their life the delivery of their baby. For the women in the study, poor and generally without much outside support, support from their family became even more important. Since insurance only gave access to DASH clinics, which were mostly located in the capital, women had to make the impossible choice of staying near good medical care or going where they would have good accompaniment from family members. Many women reported deciding for the latter. The following citations illustrate:

“I went to ‘Andeyò’ the countryside because this is where my people are, this is where I can find people to help me.” **Part. 11, age 39**

“I went to the countryside because I needed my mother and my father’s support. They can support me and advise me. There are also some remedies that are good for me and they are the only ones who know them.” **Part. 10, age 30**

This second quote also points out the fact that women usually turned to traditional medicine as one of the implications of being far from the DASH clinic. As some participants mentioned, in rural area access to hospitals can be difficult for roads in the rural area are limited. Moreover, many of the women live in communities located on the hillside with pathways that are treacherous. Therefore, traditional medicine became the easiest option, especially when leaf healers count among family members.

Even women who live within the capital city faced difficulties in traveling to the DASH facility if it was too far from their homes. In this case the transportation cost could be a discouraging factor to attend the DASH clinic, as recounted by this participant:

“When I was near the clinic, I used to go all the time. But when I moved to my new place, I stopped going. It was too much money for the transport.” **Part. 14, age 28**

Finally, sometimes even when the clinic was close, getting through or out of the neighborhood was impossible because of the insecurity. Indeed, many of the study participants lived in violent neighborhoods with high insecurity. This insecurity could take several forms, including as anti-governmental demonstrations in the streets, which could turn violent due to confrontations between the police and protesters. Gang confrontations were also very frequent in those areas. Usually, during the confrontations there were a lot of shootings and anyone near the confrontations could be harmed. Sometimes the violence was more marked, such as robberies accompanied with physical aggressions on individuals. Women were also the target of sexual abuse, especially if they were alone at late or early times of the day.

These dangerous conditions would prevent many women from seeking health care. Even in case of medical emergencies, like labor, they faced the risks associated with home birth because the risk of dying when seeking for health care was greater. This participant’s experience illustrates:

“I gave birth at home. There were a lot of shootings in the neighborhood and things were worst at the late hours. When I started to have contractions, it was impossible to go to the hospital, so I delivered at home.” **Part. 15, age 43**

Missing the insurance

As per IOM's contract with DASH, insurance was for a six-month term. For all those women, six months of coverage was a too short time. Especially for pregnant women, when a normal pregnancy is nine months. On the other hand, because several women enrolled in the program at an advanced stage of their pregnancy, they could not fully benefit from this program. In general, the study participants expressed a sense of loss when they talked about reaching the end of the insurance coverage. One participant reported that she feels it was abandonment. As many women suggested, this insurance despite all the shortcomings, was helpful as it filled a gap, and they miss it. The following quote illustrates:

"Now that I don't have the insurance, I feel that I miss something." **Part. 25, age 26**

After delivery, the opportunities for health services were fewer because the options for non-maternity related care were more limited, with a similar situation occurring for pediatric care. For those impoverished women, the insurance ended when they needed it the most. Women explained that they would have gone back to the DASH clinic if they still had the health insurance.

The gap left by the insurance was even more concerning when their children were sick. Without the insurance coverage, women were left with both higher costs and less effective treatments. Indeed, many participants recounted that very often they were forced to return to unreliable treatment like syrup bought at markets, rather than proven medicines from the clinic. Study participants recounted that most of the time they were unable to go to the doctor and would turn to alternative medicine as they used to do before the insurance. The following quotes illustrate:

“Not having the insurance is a big problem for me. I am I am sick or my children are sick, I cannot go to the doctor because I don’t have money. The only thing I can do is giving them some tea. But if I had the insurance, I would only find the money for transportation and go to DASH.” **Part. 3, age 43**

“My baby has fever for 6 days now. But I can’t take him to the doctor because I don’t have money. The only thing I’m giving him is this syrup I bought in the market. If I had the insurance, I would already take him to DASH.” **Part. 28, age 31**

This gap left by the insurance highlights its importance for the beneficiaries. When asking the women about their final comments on the health insurance at the end of the interview, they all responded the same: they wanted the insurance back. Some of the women described their grim situation to highlight their urgent need for insurance, as these quotes show:

“I am an abandoned woman, without anybody. If they could renew the insurance for me I will be very happy.” **Part. 3, age 43**

“I would like IOM to renew the insurance for me because ‘bagay yo pa bon menm,’ things are very bad.” **Part. 24, age 26**

One woman put the justification for having the insurance into a more general framework. To her the insurance, as it reduced the financial barrier to access to care, could alleviate the burden of disease for the poor. As her quote illustrates:

“I wish the insurance could continue to relieve Haitian people from diseases. Because people don’t have money to pay for care.” **Part. 15, age 43**

Darline

28 years old, a frail silhouette and too shy to look me in the eyes, Darline seemed to carry the world on her shoulders. When we met at a place near her home, she started by apologizing for her house, which she warned me is very humble. She also warned me that we would have to walk a little. We walked about 30 minutes before reaching her house. We crossed two ravines, which were filled with garbage and pigs. We also passed seemingly interminable corridors with small houses on both sides, many displaying products for sale, such as small packages of detergent, rice, beans or charcoal. Crossing another small corridor, which I later learned is also her kitchen and her shower, we finally reached Darline's house,

The single-room house is on the top of the hills with a breathtaking view of the sea, which contrasts with the grim aspect of the place. Darline faintly invited me in, apologizing once again for the state of her home. The room is minuscule with walls made of mud and the roof covered by waste metal sheets. The house has few items: two twin-size beds covered by some worn sheets, one table with a few cooking supplies, and one chair. There's no TV or radio. Four of her five children were playing on the dirt floor, although it was a school day. "The eldest is in the streets with his dad," she told me. "*Yo ale brase lari ya*" (they are trying to find whatever they can in the streets), so my son can bring us something to eat. We did not eat anything yet we are waiting for them." I looked at my watch. It was 12:20 PM. *Mesie ya* (mister), as she calls her partner and father of her five children, is the only one who has a job in the family. He sells water bags in the streets and on the best days he can make 125 Gourdes (\$1.63). "This is how we live, day by day", said Darline. We sat next to each other on one of the beds while she breastfed her one-year-old baby. During our meeting, the baby kept crying. He was obviously hungry and didn't seem to be getting much milk from his mother's breast.

Darline was 14 years when her sister took her to Port-au-Prince. For two years, she stayed at her sister's house, babysitting her two nephews, doing the main tasks in the house, while her sister worked in the market. At 16 years old, she became pregnant by her current partner and moved with him to their new place. Over the years, in addition to taking care of the house and the children, she also had an informal and sporadic business. She used to sell charcoal, fruits, and even boiled eggs along with bread with peanut butter, which is a common breakfast in Haiti. Sometimes she would display her products in front of her house and sometimes she would walk kilometers in the streets. During these times, she recounted with a certain pride, she could easily make 75 to 125 Gourdes (\$1.22 to \$2) a day. In 2010, after the house they were renting collapsed, the family moved to a camp in Carrefour where they lived for five years. In 2015, she was six months pregnant when she enrolled in both the IOM relocation program and the IOM insurance program. With the 20,000 Gourdes (\$328) provided by the relocation program, she paid a one-year rent and kept \$100 for a small business.

After moving from the camp, the family felt things were getting a bit better. They had a roof over their head, they had medical insurance and both had a *ti demele* (a small business). But quickly their situation changed. The baby became sick and since the insurance had expired, Darline had to take him to other hospitals, paying for everything. She recounted that one day, she had to pay 900 Gourdes (\$15) just for lab tests. It was more than she could afford. After spending almost all of their means without seeing any concrete results, the couple decided to take their baby to the *hougan* (Vodou priest) and they undertook a treatment for 2,000 Gourdes (\$32), which they are still paying. As Darline recounted, her baby's sickness devastated her family economically. All her meager savings were gone, her business went broke and the other children could not finish the

school year because she was unable to pay the required annual \$41 fee for each of them. Hunger also became an increasingly regular part of this family's life.

While they were fighting against the disease of their child and its financial implications, the one-year rent paid by IOM came to an end. The family had to move to a cheaper place, as they could not afford the former rent. For Darline, it was an accumulation of misfortunes. "As you see me now, I was bigger," she said to me, "but all those problems and all this rumination wasted me. This is why I am so thin," she added looking down, as she was apologizing for her situation. After a short silence, she continued talking but her voice tone was higher. Suddenly, she was mad. "You know, she said, in this country nothing is for free. Yes you have to pay for food, for your rent, for school, for care. You have to pay for everything, when you have nothing." But to her, the most difficult part was the sense of being alone and invisible in the midst of her struggle. As she kept talking, she seemed to be releasing her grief against this society that excluded her: "You are here, but nobody sees you. It is like you were not in the society, like you were not there. They humiliate you. You don't feel comfortable in your skin. You never find someone who comes to you and asks you how do you live? How do you do without?" A long and heavy silence followed. Then I decided to break the ice and turned the conversation to her experience with the IOM insurance.

When she started talking about the insurance, Darline's face softened. She said the insurance would change her calculation about seeking care. Access was easier and prices cheaper. But to Darline the most valuable gift from the experience of having insurance was the fact that she could own something that is normally reserved to a higher social class. As she described with a certain sense of pride, for the first time in her life she felt part of the society. To her, having insurance included her in a larger citizenship. She was no longer invisible: "This is what I like about the health insurance; I feel like I am part of the society. I feel I exist, that they see me."

It was around five PM when I left Darline's house. Her eldest son was still not back. Her baby finally fell asleep after she gave him some sweetened water. The other children were sitting in the corridor, their eyes fixed in the same direction, as if they were desperately waiting for someone. Darline avoided their gaze and as we were kissing goodbye, she turned her eyes to the sky like she was making a prayer.

7. Discussion

Acknowledging the poor

In this study, issues of power, class divisions and discrimination arise repeatedly from the data. Whether mentioned explicitly or implied by the participants, these issues lie at the core of their reflections about their experience with health insurance and, more generally, about their own situation in society. In our results, we found that some women equated access to insurance with social visibility. In fact, a participant's perception of insurance impacted her decision to use it. The social dynamics of Haitian society and the social conditions of the women create this perception. The different feelings that accompanied insurance ownership shine a light on the structure of Haitian society and its impact on the most vulnerable groups.

Haiti houses two worlds (Fatton, 2002) –the haves and the have-nots –which succeed in cohabitating and yet barely see or acknowledge each other. Class, economic status, language and even religion, all divide the elite and the *pèp*, as the poor majority is usually called. The elite represent the minority. They often speak French, are well educated, wealthy and powerful. The multiple appellations used to name this class in the local language include *Gwo Zouzoun* (important people), *nèg anwo* (people of the hills), *roche nan dlo* (pebble in water). These local terms illustrate the skewed distribution of wealth and power between the elite minority and the poor majority. Statistics show the reality of these inequities in the Haitian society: the richest 20% of Haitian citizens hold 64% of the total income of the country while the poorest 20% barely holds 1% (World Bank, 2015). Less than 1 out of 10 poor women benefited from facility-based childbirth delivery versus seven out of ten in the richest group (MSPP, 2012a). Even higher disparities exist between the urban and rural areas. Robert Fatton Junior, a Haitian author

who brought an important contribution to the emerging field of Haitian Studies, argues that these two worlds are bound together in “unequal and interdependent relationships” because the poor depend on the elite who control the wealth of the country (2002, pp. 52–53). However, as the same author points out, all the wealth and status of the so-called dominant class largely comes from its control and taxation of the poor majority (Fatton, 2002, pp. 52–53).

In such a peculiar relationship, where dominant and dominated live geographically close and the wealth of the dominant class depends upon the workforce of the poor, a clear distinction between the two worlds is necessary to preserve the power balance and the status quo. Both physical and psychological barriers separate these two populations. Hence, Pétion ville is among the historically wealthy neighborhoods of Port-au-Prince, and sits on a hill set apart from the poorer neighborhoods. Walls and gates surround many large homes in this neighborhood. The elevation and these structures present a physical barrier between these wealthier people and the poor of Port-au-Prince. In addition to these physical barriers, the wealthier also distance themselves emotionally from the so-called “social inferiors.” This distance between those two groups creates the “social walls” in Haitian society (Trouillot, 1995). These social walls preserve a strong, impenetrable barrier between classes and ensure that the poor stay invisible, and these walls represent a form of rejection or denial of the poor in the society. This rejection continues the history of social isolation that masters imposed on slaves to maintain power and the system of exploitation in Haiti’s colonial society (Brodwin, 1996, p. 31). Indeed, the slave was considered as socially dead (Patterson, 1982), and denied access to the most basic human rights. Masters did grant slaves one essential right: a right to health care, though only of the poorest quality (Brodwin, 1996, pp. 34–35). Slaves enjoyed this “right” because as laborers they drove

production in the plantations of Haiti. A healthy slave could continue to work and produce the crops that provided wealth for those in power.

The social suffering of the poor in Haiti stems from a long history of intentional oppression. Laurent Dubois, specialist of the culture and history of the Caribbean especially Haiti, notes that “Haiti’s state has been quite successful at doing what it was set up to do: preserve power for a small group” (Dubois, 2012, p. 7). The country’s political structures remain largely unaccountable and impermeable to the demands of the majority of less-advantaged Haitians (Dubois, 2012). However, in the midst of the structural violence, poor Haitian people always claim their rights as citizens, to be part of political arena and also for access to good education and health (Maternoswska, 2006). But if the poor can still claim a position in politics, health and education still remain out of reach for most of them.

In this context, access to insurance holds powerful symbolism. Many women expressed their feelings about owning insurance using the expressions *Yo wèm* (They see me) or *mwen senti mwen la* (I feel I am there). Those expressions in Haitian culture mean more than simple visibility. They express the recognition of the person as part of the larger social whole. Women in this study were highly attuned to these social walls that have grown out of the deep inequalities that shape Haiti’s social and economic history. They understood that private clinics were out of reach for people “like them.” When they were given access to health insurance, these women felt that they were being given not only the opportunity to access a high quality clinic, but also the chance to cross over these social walls. The insurance represented inclusion in the larger social body from which they had been excluded most of their lives. Insurance was experienced as evidence of citizenship and belonging.

The clinical encounter: when possession of insurance translates into access to care

While possession of insurance was an important and validating experience for many women, the use of their insurance was often fraught with challenges posed by broader social and economic barriers. The women enrolled as IOM insurance beneficiaries were poor camp residents who traditionally have not had access to private hospitals. With the initiation of the insurance program, these individuals mingled with the staff and primarily upper middle class patients at the private DASH clinic. Our data demonstrated that women's first encounter with the clinic – the important moment of “reception” – largely shaped their view of whether the access provided by insurance would translate into care. This initial clinical encounter was largely shaped by prevailing social dynamics present within Haitian society. As described by Howard Waitzkin, a primary care practitioner, professor of sociology and author whose work focuses on social conditions that lead to illness, unnecessary suffering and early death, “clinical encounters become micro political situations that reflect and support broader social relations, including social class and political-economic power” (1991, p. 9). Women in our study were quick to decipher whether or not they were welcome at the clinic, immediately reading the words and body language of the staff. Reception was so important to women that even *hearing* about other women's negative experiences was enough to keep future users from attending the clinic.

The importance of reception was echoed in the results of our quantitative survey. A good reception was the third most common factor of satisfaction with the health insurance reported by the participants, following easy access to a physician and lower cost. This coincides with what most of the women reported during the interviews: satisfaction with the reception was another motivation to use the health insurance. Many studies in middle and low-income countries have indicated that the quality of reception at the clinic affects patients' desire to attend the clinic. In

their study on the determinants of delivery service use among pregnant women in different middle and low-income countries, Gabrysch and Campbell found that the reception by medical staff was an important factor for the use of medical services. The same finding has also been reported by Amooti-Kaguna and Nuwaha in their study on use of medical services among women in rural Uganda (Amooti-Kaguna & Nuwaha, 2000; Gabrysch & Campbell, 2009).

Some women in our study reported that clinic staff labeled them as “poor camp people” because they had IOM insurance. The stigma that accompanied the insurance stands out as a major unanticipated consequence. When women in our study felt stigmatized by being labeled and treated as poor patients visiting a private clinic they chose to leave the clinic and pursue care at other facilities where, as they explained, the staff was “used to people like them.” The medical anthropologist Catherine Maternowska’s analysis of a family planning program aimed at women in Cite Soleil describes how women attending that clinic were identified as “poor,” a stigmatizing label that led many to stop attending their clinic appointments (2006b) . Like the women in Maternowska’s study, DASH recipients faced many aspects of structural violence in their daily life. The stigmatization that they encountered at the clinic served as a crystallization of the myriad complex social barriers that structure the lives of impoverished women in Haiti. Our study demonstrates that although the ownership of insurance can be empowering for some women, having access to insurance was not always enough to overcome the significant asymmetry in power between social classes. This is yet another demonstration of the way in which the social barriers that shape the lives of poor women in Haiti affect the kind of health care available to the very poor.

Fueling the structural violence of the poor: the cost of user fees

Health care in Haiti is based on a user fees system (MSPP, 2012b), which means that access to care is directly related to the individual's capacity to pay for health services. Despite a national vision for universal access to health care (Constitution, 1987; MSPP, 2012b, 2014) and efforts to guarantee free access to different services (such as maternal and child health and vaccination supported mainly by international donors), lack of coordination between stakeholders created a fragmented health system (MSPP, 2012b). Indeed, geographic access services coverage and prices differ depending on the provider and the location. Moreover, the vertical approach used by many international entities that fund these health care initiatives creates a separation of care based on disease. The net result of this particular history of funding health care interventions is a fragmented national health care system. Multiple overlapping interventions exist, and most are heavily concentrated in urban areas. As health care is structured by individualized interventions, each health care package is often incomplete, providing only a limited number of services.

For the study participants, such a system has dire implications, because they are poor and have a high burden of responsibilities. Indeed, 75% of the participants have a daily income between zero and two dollars, and out of those 42% live on less than one dollar per day. Even so, a large imbalance exists between income and burden of responsibilities. While in 42% of the cases the study participant's partner is the primary breadwinner, most of the women bear the responsibility to provide food, rent, health and other commodities for the family and sometimes, other relatives. This distribution of responsibilities among women and men is very common in Haitian society and has been described as the "*Contrat des sexes*" (Contract between sexes), by Mireille Neptune Anglade, Haitian economist and author of several publications on the work of

Haitian women (Neptune-Anglade, 1986, p. 16). The imbalance between responsibilities and financial means reduces choices in the short term and leaves little room for contingencies like diseases. The impoverished women in the study very often make impossible choices between accessing health care and addressing other competing needs like food and education.

The trade-offs that poor women have to make in order to pay for health care have been pointed out by Priya Nanda, a health economist with large expertise on issues related to gender, in her study on the implications of user fees for poor women utilization of health services (2002). Looking at the experience of poor women in many African countries like Tanzania and Ghana, she argues that user fees enormously hamper women's capability to access health care (Nanda, 2002). The study participants provided with great details of how out-of-pocket health expenses reduces their agency. They were often left with no choice but to turn to traditional medicine, which is usually more affordable but that did not address their health needs, or to simply give up on accessing any type of care. The women's report of their experience with user fees contradicts the common erroneous belief that negative health outcomes of poor people are related to their reluctance to seek for health care. Health is a priority for them even if they expect that they cannot afford it. This echoes the call of the Nobel Prize laureate, Amartya Sen, for a distinction between "health achievement and the capability to achieve health" (2002, p. 660). As he points out: "people tend to give priority to good health when they have the real opportunity to choose" (Sen, 2002, p. 660).

Navigating a fragmented health system

In such context of poverty, some of the participants found that health insurance alleviated the challenges associated with a fragmented health system. As many women reported, the DASH

insurance meant that access to care was always possible, even without money. According to them, this certainty of access reduced the usual cost calculation for care and provided them with peace of mind. In this study, the insurance improved their access to some components of health care, such as medical consultation. Indeed, the quantitative results reveal easy access to the doctor as the number one reason for satisfaction of the participants. The study also suggests that having insurance had a positive impact on utilization of medical services. Although there was not enough power to control for possible confounding in our quantitative results, both our quantitative and qualitative results converge to show that having insurance meant women were more likely to seek care at the clinic. Those results are also consistent with several studies in Asia, Latin America and African countries that demonstrate an impact of insurance on utilization of medical services. For instance, one study in Rwanda shows that the odds of using medical services are higher for enrollees in the national health insurance, the “*Mutuelles*,” than the non-enrollees (Lu, Chin, Lewandowski, Basinga, & Hirschhorn, 2012). Another study in nine developing countries in Africa and Asia reports an increased use of medical services after the implementation of the national health insurance in Ghana (Lagomarsino, Garabrant, Adyas, Muga, & Otoo, 2012).

Nonetheless, many women noted that the insurance was insufficient, not only because of the incomplete coverage, but also because of the limited geographic coverage and the short duration. Even the insurance is emblematic of Haiti’s fragmented health system. Similar to the health services delivery in the health system, the IOM insurance offers a limited package of services that does not fulfill the health care needs of the beneficiaries. This incomplete insurance package would be more convenient if it worked as a complement to the existing services delivery in the system, especially facilitating the access to essentials services that are financially out of

reach for poor people, such as facility-based delivery. Rather, as the study showed, the IOM insurance often missed the “essentials.” This poor coverage of services is less likely to make an impact in the Haitian health system where service delivery is very limited, because as the physician-anthropologist and author an large bibliography on health and social justice, Paul Farmer, points out, “a minimum package presupposes the existence of a bigger, even a maximum package” (2015, p. 7).

The incompleteness of the insurance raises a fundamental question about the relevance of the minimal package. As the participants explained, this package was not only incomplete; it did not even address their main needs. Indeed, childbirth/delivery was not covered by the insurance, in a context where one of the biggest public health challenges is to decrease the rate of maternal deaths previously shown to be closely associated to non-institutional delivery (MSPP, 2010, 2012b, 2013). Despite their appreciation for greater access to medical consultation, participants found that the package offered by the insurance was insufficient. Indeed, as per the results the impact of insurance on out-of-pocket expenses for delivery is nil. The insurance also did not reduce out-of-pocket expenses for ultrasound, another challenge for poor people because of the high price on the market. These results do not come as a surprise. In their study on health system reform and universal health coverage in Latin America, Rifat Atun et. al., report a meaningful package of service as one of the key factors to ensure an impact on health expenses (Atun et al., 2015).

Therefore, the other question is “what are the implications of this limited package for the beneficiaries?” As the study demonstrates, the beneficiaries are the ones who have to make sense of the fragmentation of both the system and the insurance. The women talked about how they would shop around, strategically making use of the benefits, assembling the pieces of the

puzzle. This pattern of women's strategic health care "shopping" has been reported by other studies (Shaikh & Hatcher, 2005). However, choices for poor women are very limited within a system where access to health depends on economic means. As demonstrated in the results, most of the time women are constrained to the restricted package offered by the insurance. Indeed, 48% of the participants reported that they were not able to access the care that was not covered. This reduced package from the insurance puts a high toll on poor women. As they reported, the *monte desan* (running around) resulting from this can be tiresome and sometimes even dangerous. The relative certainty of access that the insurance provided would turn into a sense of abandonment. This shows that insurance with a reduced package of services is not the best choice for the poor. The experience of many countries, like Cuba, Brazil and Chile demonstrate that an expanded package of services is one of the conditions to achieve equitable coverage (Atun et al., 2015).

The main goal of the DASH health insurance was to mitigate the financial and also social barriers to health care for the poor. However, the study shows that the experience of the women with the insurance is quite similar to their own experience within the larger health care system. In essence, the insurance is just as incomplete as the health system. Moreover, the power dynamic is also quite the same: women had no power to negotiate the terms of this insurance to fit their needs, as they never could negotiate the type of health system that will fulfill their real needs. This lack of negotiating power pushes us to think more deeply about the level of the women's satisfaction with the health insurance. Although most of the participants openly expressed their points of dissatisfaction, and a few formulated direct recommendations, most of them reported being satisfied with the insurance and the vast majority claimed that they wanted the insurance back. This contradiction can translate to two factors: first that the insurance,

despite all the imperfections, was valuable for the beneficiaries, especially in the context of poverty where agency is constrained and people are deprived of almost everything. Second, the beneficiaries feel the “obligation” to be satisfied with the program, as part of the exchange process between the NGO that provides the aid and the beneficiaries who give their consent or express their gratitude in return (Krause, 2014, p. 59). Those two possibilities are not mutually exclusive.

Even when clinical services are readily accessible (both financially and geographically), navigating health care can be difficult for individuals who have limited access to resources and support. For the women in this study, accessing care became increasingly complex as they tried to learn which clinics they could and could not go to, as they managed being welcomed or not and as they had to assess the personal and financial cost of seeking care in one place yet delivering in another. In a country with an inequitable access to services, the insurance was supposed to increase access by removing or simplifying barriers. Although access increased for some women, for too many the added complexity, and the irrational limitations made navigating health care in a non-existent system even more strenuous.

Behind the scenes of the IOM insurance

Most of the limitations of the health insurance program were inherent to its initial design. As the study participants indicated, a six-month term is definitely not appropriate for a program that includes pregnant women. As noted above, the package of services is not suitable either; it even misses the “biggest parts,” like delivery. Although the insurance resulted from the identification that camp residents needed access to health care, there was no deeper assessment to inform its design. Furthermore, whereas the beneficiaries were the main justification for

creating the program, they were not involved in the conception or the implementation of the program. As usual, they were informed at the end, and had to accept the project the way it was without having the chance to give their insights. Including the beneficiaries into the program development process would have helped a great deal in capturing their real needs and creating a program that fits their reality. Ironically, this missing point is closely linked to the rationale of the intervention.

The IOM insurance program, similar to many other NGO projects, follows the rationale of the humanitarian intervention. The main purpose of the intervention is to produce a project that fulfills the donor's will, so it gets funded, and that funding can then be used to help keep the NGO going. Many times, even if the beneficiaries are the justification for the intervention, they are not the main motivation for doing it. The sociologist, Monica Krause's argument on the humanitarian work helps in understanding this point. In her book on the logic and practice of humanitarian relief agencies, she describes relief as a "mode of production, which product is the project that is sold in a market where the donors are the consumers. In such context, the beneficiary becomes commodity that it's sold within the project to the donors"(Krause, 2014, p. 4). The implications of such logic of intervention are thus multiple. Because NGOs depend on donor funding, donors' needs will prevail over beneficiaries' needs. Thus, quick and sound results are required to justify the donor's money flow so agencies will focus on "short-term intervention for selected beneficiaries" (Krause, 2014). From 2011 to 2014, the donor's attention was focused on the relocation of the internally displaced people in Port-au-Prince. IOM was among the lead executing agencies of this government initiative. The IOM insurance program benefitted from good timing. This component of the insurance was an added value for the institution, in the sense that it enhanced the importance of the intervention. However, they had to

adjust to the timeframe of the donor's funding, which was eight months. The logic was to very quickly produce a project and provide the donor with results, as evidence of good performance. There was not much time to consider what people really needed, especially if their needs were too complex to be addressed rapidly.

Despite all the imperfections, the study shows that the insurance also had positive outcomes. People benefited from the program during those six months it was ongoing. However, for poor people who have been denied almost everything in the society, this insurance seemed to have to provide a glimpse of the “house of yes“ to beneficiaries, the way Farmer framed access to good quality health care (Farmer, 2013, 2015). However, the unanticipated consequences of such short-term interventions, like the sense of abandonment they can create, raise concerns about the impact of short-term interventions on people lives. Many humanitarian workers justify this “short term” approach because their intervention is a bridge to eventual takeover of state responsibilities. Citing Werner Sholtz, Sharon Abramowitz, an anthropologist who conducted several studies on humanitarian intervention, describes this form of intervention as the “ ‘custodial sovereignty of the NGO, which suggests an arrogation of rights by the latter in the absence of capacity of the host state’ ” (Abramowitz, 2015, p. 140). This sovereignty also implies that NGOs have the freedom to put terms to their intervention when they perceived that the state is able to take over or when they don't have the capacity to sustain their intervention. In Haiti, the drastic decline of international relief five years after the earthquake did not coincide, however, with any indication of the state's capacity to take over the work of the NGOs.

A corollary of the custodial sovereignty of NGOs that allows them the freedom to control the structure of their intervention is that those organizations can act like a state within a state. Haiti's weak health system allows NGOs to challenge the role of the state as the main entity

responsible for addressing the needs of its population. For most countries, the state oversees the structure of the health system and regulates health insurance and access. Whereas few governments provide the single payer health insurance/care system offered by places like Great Britain and Canada, most countries at least regulate health insurance and health access through some social program. By offering this health insurance to people who otherwise would not be able to access it, IOM essentially took over a role traditionally held by the state. While much has been written about the inability of weakened states to provide health care for its citizens, this case presents a situation in which an outside entity (the IOM) provides insurance, which is the promise of access to health care. As the study shows, this insurance in essence represented a “restoration of their citizenship” or a sign that these disadvantaged women gained a degree of inclusion in society. The fact that this NGO provides this “citizenship,” which should be provided by the state, could suggest at first glance that the state failed to address the needs of its citizens. In reality, structural forces make it impossible for the state to meet these needs. Indeed, the same power dynamic that prevails in Haitian society also exists between the Haitian government and the international community. Because Haiti is so impoverished, it is much like these women: poor and subject to the whims of those who wield power and money.

When reviewing official documents such as the Haitian constitution and the different national health policies, we discover important contradictions between the national vision for health and the current health situation. Indeed, principles of universality and equity lie at the core of the Haitian health system. There is also a keen sense of the different public health challenges, especially the important inequities within the system (MSPP, 2010, 2012b, 2013, 2015). However, the Ministry of Health does not have the financial means to sustain its vision. The Haitian government finances only 10% of the total health expenses, whereas the international

sector contributes up to 52% (MSPP, 2014). This high dependency on the international community carries great consequences for the authority and leadership of the state. The state's dependence on multiple sources of outside aid serves in practice to create a fragmented health system. Multiple donors fund different programs, sometimes resulting in duplication and overlap, and at other times resulting in competing priorities. The end result is that the state finds itself unable impose its unified vision of how to best provide for the health care needs of its citizenry.

Haitian people many times have tried to resist the hegemony of the international community. They know that because international funding is often blended with international politics, international funding does not necessarily meet local needs. Ary Bordes, a former Haitian health minister and longtime pioneer in Haitian preventive medicine, warned about the politicization of international aid and its frequent independence of national needs (Maternoswska, 2006). Bordes was also aware that health is only a symptom of poverty and therefore health needs could only be addressed within a holistic approach to people's needs. In the early 1960s, Bordes's program for family planning in Cul-De-Sac combined health activities with literacy and economic development activities. Bordes's program serves as a good example of a horizontal vision of health opposed to the vertical approach proposed by international donors (Bordes & Couture, 1978). The outstanding outcomes of the project that corroborated the pertinence of Bordes's vision of a holistic approach to addressing the population health needs. However, in the late 1960s, donors imposed the vertical approach to family planning, which is still the prevailing model in the present day (Maternoswska, 2006). Again, as a financially disadvantaged country, Haiti's experience mirrors that of its lower-income people: the Haitian

government is not in the position to negotiate the type of health system they want for their citizens.

The toll of history and global development on the health of poor Haitian

The asymmetry of power evoked in our study highlights the way in which citizens, especially the poor, find themselves unable to negotiate access to care that is holistic, long-term, and pertinent to their needs. As our study demonstrated, a set of historically-based social and economic inequalities often structured the kind of limited choices available to the women in need of health care. These inequalities are symptomatic of a broader imbalance of power between the Haitian State and the international community. In much the same way that the inequalities facing women in our study were the result of longstanding, historical inequities, the current state of health care in Haiti is reflective of a unique history that favored the interests of dominant classes – both local and foreign.

In the late 18th century, Haiti (then called Saint Domingue) was the one of the most prosperous colonies in the world, which earned it the name of *Perle des Antilles*- Pearl of the Antilles- (Madiou, 1847). By 1789, it was producing two-thirds of all overseas trade of goods imported into France (Maternoswska, 2006, p. 135). This massive production and prosperity was possible because of its important productive labor of half a million slaves, who represented 87% of the population of Saint Domingue (de Saint-Mery, 1958). This overwhelming majority was perceived as a real threat for the dominant class who tried to control them by all means, ranging from extreme physical sanctions to the social construction of the black as socially dead persons that prevented the slaves from having any true rights (Patterson, 1967, 1982). However, because of the profitability of their labor for the system and the fact that they represented a substantial

economic investment for their owner, the slaves were given some access to health care. The enslaved person was therefore treated as a commodity that required very basic care. As the medical anthropologist Paul Brodwin indeed confirms, this care was the bottom rung of European medicine in Saint Domingue (1996a, p. 31). While the white people were entitled to the best health professionals in the colony, slaves were only allowed to receive care from female slaves called *hospitalière* and non-qualified surgeons. But contemporary medicine was not only deployed to protect slave labor, it was also used by the dominant class to exert their power over the black majority by introducing their local world to forestall slave potential reaction to their conditions and to control any potential resistance (Brodwin, 1996, pp. 34–35). Therefore, during the colonization, the colonists' economic interests and need to exert power to preserve those interests shaped health.

The French colonization set the tone for the structure of Haitian society, its production and also the Haitian public health. In the post-independence era, the new elite –constituted mainly by new black and mulatto—was mostly focused on politics as the fastest path to power and health. They were concentrated in the big cities, including the capital. Agriculture was left to the former black slaves, who became peasants living in rural area. This created two distinct groups, which Brodwin describes in this way: “Haitian society thus bifurcated into two geographically and culturally distinct groups: an urban elite which controlled state revenues and a reconstituted rural peasantry farming small, independently owned plots and lands” (Brodwin, 1996, pp. 46–47). As in the colonial period, access to medical care was a prerogative of the dominant class and providers were concentrated in the capital city. There were very few medical services in the rural areas, which pushed the vast majority of the population to use the services of traditional healers or non-certified trained doctors, the charlatans (Brodwin, 1996, pp. 46–47).

This situation is reminiscent of the current Haitian health landscape, where access to health is skewed in favor of the urban elite.

According to Maternowska “when the United States staked economic interest in Haiti, political interest soon followed” (2006, p. 137). Indeed, Haiti was a good provider of raw materials, such as coffee and cocoa. As Nicholls contends, it was also an attractive place for foreign investment (Nicholls, 1979, p. 148). To advance their interests, the American government infiltrated all the national institutions during its occupation of Haiti from 1915 to 1934. This “authoritarian paternalist” approach as Brodwin calls it, was based on the (presumed) Haitian people’s inability to govern (Brodwin, 1996, p. 48; Farmer & Bertrand, 2000, p. 67). The American occupation changed the face of Haitian health. Putting Haitian people aside, especially the elite, the US occupiers took over health management through the creation of the *Service National d’Hygiène et d’Assistance Publique*, the future Ministry of Health. Administrated by the Americans, this institution controlled the entire health care system, ranging from medical teaching and practice to the construction and management of health facilities (Brodwin, 1996, pp. 48–51). During the American occupation, health was expanded to the rural areas, reaching the poor. In the pursuit of their “development” goal, the Americans focused on building infrastructure, such as roads and government buildings. However, they were not interested in building any national expertise. American experts, following American standards and without any regard for local will or values, managed the whole machinery without building local capacities or allowing local practitioners to play any role in leadership.

Under the occupation, the American administration operated in a way that resonates with the “custodial sovereignty” of the NGOs. The Americans replaced the undermined state in its role of the main provider for Haiti’s citizens. Many will argue that the poor were better off,

especially since for the first time they had access to health care, which was a prerogative of the minority elite. However, the export-oriented economy developed by the Americans took a high toll on the lives of the poor. Maternowska, citing Farmer, contends that “ ‘the coffee-producing peasants lost up to 40 percent of their income on federal taxes’ ” (Maternowska, 2006, p. 137), perpetuating the exploitation by the French and the urban elite in Haiti. The health initiatives undertaken during the period of American occupation are yet another incarnation of the kind of medical interventionism that has been a part of the international “development” of Haiti since the period of French colonialism. As the French philosopher Michel Foucault’s theory of bio-power illustrates, biomedicine is an important tool in monitoring and control of a population (Foucault, 1990, p. 140) . The various public health interventions imposed on Haiti during this period served largely to further the economic interests of foreign governments. The effects of these interventions on the lives of Haiti’s peasants has been described by Farmer and Bertrand as “hypocrisies of development” (Farmer & Bertrand, 2000). Often supported by the local ruling class in Haiti, international powers have used the pretext of “development” to advance their own interests. The intrusion of neoliberal ideologies into the local world of Haiti and their implications for poor people is a manifestation of this hypocrisy of development.

One of the central tenets of the development schemes that we have discussed is the practice of user fees. The idea to require people like Darline -and the other women of the study pay for health care did not come from poor people like them. This was a decision of great international powers fighting for the control of the market. As the physician-anthropologist Salmaan Keshavjee accounts, neoliberalism arose as a “bulwark against communism” (Keshavjee, 2014, p. 89). This profitability-focused ideology reduces the role of the state to a mere facilitator of the market, “liberating” it from its responsibilities to provide for the health

and welfare of its citizens. The economic crisis in the early 1980s offered a good opportunity for wealthy countries to extend their control over the global market. By this time, most of the developing countries already profoundly indebted had to borrow from the International Monetary Funds, IMF (Keshavjee, 2014). The IMF put the adoption of the “structural adjustments” to the developing countries economy as the main condition to access any loan. These adjustments, as Keshavjee describes, consisted of three words: stabilization, liberalization and privatization of economies (Keshavjee, 2014, p. 90). In practice these measures gave way to:

- 1) The cutting of government spending to reduce inflations, which concretely implies reduction of government investment in health, education and social welfare;
- 2) Freeing prices by eliminating government participation in the market;
- 3) Selling state assets to the to the private sector in order to reach more efficiency (2014, p. 95).

In Haiti, as in many developing countries, these structural adjustments caused the decrease of funding for social services, the introduction of user fees for public goods (such as health and education), and decreased prices on local production (mainly foodstuffs produce by Haitian farmers).

While neoliberal policies like user fees are touted as beneficial to recipients, in practice, the objective of such mandates was to maximize the profit for wealthy donor nations to the detriment of poor countries. As Jones contends: “the language of profit, efficiency and consumption replaced that of citizenship, solidarity and service” (Jones, 2012, p.344). This ideology was certainly contrary to the values of most developing countries, including Haiti, but leaders of the recipient countries had no capacity to negotiate the harsh terms associated with these loans. These neoliberal policies served ultimately to undermine the capacity of the indebted state,

opening the door for international NGOs to take control of the practices and responsibilities once associated solely with the nation state. NGOs became the main channel for the neoliberalism policies and agent of application of international agenda, aligning foreign policy with development aid (Keshavjee, 2014, p.107). In the late 1970s and early 1980s in Haiti, the Duvalier regime, using the justification of the prevailing critical economy in the country, encouraged the massive infusion of international aid, especially from the powerful USAID (Farmer & Bertrand, 2000, pp. 69–70) . This period contributed to the rapid spread of NGOs throughout the country, a trend that ultimately supplanted the role of the state as provider of health services.

But as Farmer and Didi Bertrand, a Haitian anthropologist, suggest, this massive infusion of international aid in this period contributed to make the poor worse off (2000). As an example, the authors discuss the devastating consequences of the USAID cereal donation program on the Haitian economy, which undermined the production of cereals by local farmers (Farmer & Bertrand, 2000b). Haiti became more and more dependent on foreign food. In 1994, Haiti's food imports were estimated at 77% compared to 24% in 1980 (UNDP, 1997). The consequences of neoliberal policies and the massive infusion of foreign aid also had adverse effects on the health sector and more specifically on the poor. Indeed, as the former general director of the Haitian ministry, Dr. Dubuche, contended during a presentation in June 2014: "Haiti is the beneficiary of the generosity of the international community, but also its victim" (Dubuche, 2015).

Haiti became increasingly dependent on international funding. Indeed, the international contribution to the national budget rose from 9% in 2000 to 25% in 2005 and 52% in 2013 with a peak of 91% in 2010 after the earthquake (Dubuche, 2015; MSPP, 2015). As a consequence of the low public health financing, Haitian households ended up bearing a large portion of the

health budget. Indeed, 32% of the health expenses are financed by the households in a country where 80% of the population is poor (MSPP, 2015, p. 20). This translates into large inequities in terms of access to care and negative health outcomes, once again at the expense of the poor.

We can see that the poverty, deep inequities and stigmatization voiced by the women in the study are symptomatic of a larger history of intervention in the name of development. This review of the different periods of Haitian society also demonstrates that the economic interests of powerful forces have always shaped health in Haiti. Reviewing the origins of the neoliberalism ideology and its infiltration of the global health system helps us understand why the Haitian state is often incapable of negotiating policies that reflect local values and needs. This historical context also provides a better understanding of the nature and practice of the development schemes examined here. Programs like the IOM subsidized health insurance are following a long legacy of interventions designed in a way that does not get at the heart of the real needs of the program beneficiaries.

8. Study limitations

The study presents three main limitations as detailed below. Those limitations are mostly related to the challenges faced when we conducted the study in the field.

1. Insufficient quantitative sample size

Given challenges in recruitment, the target sample size was not met. Therefore, the quantitative analysis was limited to descriptive results.

2. No comparison analysis

Since there was no control or comparison group for this study it was not possible to discern if the self-reported increase in access to healthcare may have been related to other factors that changed over time other than the health insurance program intervention. However, given the overall acute challenges in access healthcare and related costs, it is likely that other factors would have worsened the situation rather than resulting in improvements.

3. Participant recall bias

Participants may also be biased in their recall of healthcare access and costs, and may be more likely to recall better quality of care in light of the health insurance program. However, in the informed consent we indicated that the study was about reviewing the health insurance program and that their perspective would help to inform improvements in the future.

9. Conclusion

Financing health care in Haiti has long been a challenge, as governments aspire to reach the constitutional mandate of health care as a human right with a limited budget. Foreign partners and local associations have tried to fill the gap and the result has been a fragmented health system built on a history of political decisions and programmatic mandates from donors and local officials with limited consideration for the most vulnerable. In 2013, IOM designed an intervention that would provide coverage by subsidizing insurance for internally displaced people living in camps after surviving the earthquake of 2010. Through this study, we have explored the functionality of this IOM health insurance and the lived experience of the insurance beneficiaries as they navigated the health system. Our results demonstrated that the insurance scheme did not properly meet the health needs of its beneficiaries. Specifically, the program was too short in duration to address women's longer-term health needs, as exemplified by providing only six months of care to pregnant women. Furthermore, many of the medical services that women identified as most important – notably delivery – were not covered by the insurance.

By placing the IOM program within the broader history of medical intervention in Haiti, we have examined the historical roots of the flaws of this particular program. Tracing this history has also allowed us to identify the roots of the social suffering represented in the words and experiences of the women in our study. Based on this historical review, we argue that policies driven by the economic and political interests of local and international powers contributed to create a fragmented health system that ultimately fails to improve the health of the Haitian poor. In this account, the IOM insurance program can be understood as symptomatic of a long-standing history of fragmented interventions that are inadequate to meet the needs of the poor.

One of the legacies of this tradition of health intervention that weighed heavily on the women in our study was the institution of user fees. Our study results challenge the presumed benefit of user fees, rejecting the prevalent idea that user fees improve care quality and increase individual's personal care seeking freedom. The women used their own experiences with the IOM insurance to demonstrate that user fees left them with little control over their health, and further increased the gap between Haiti's "haves" and "have-nots," fueling inequality and structural violence.

This research demonstrated the dissonance between the implementers of this insurance scheme and the beneficiaries of the program. It sought to reframe the outcomes of the insurance program by highlighting the words and lived experiences of the women enrolled in the IOM insurance program. The women encouraged us to go beyond an examination of the functionality of insurance, and listen closely to what the program meant to them. Their experiences highlighted a variety of unanticipated outcomes. On the one hand, our results demonstrated health insurance left them exposed to social discrimination within the private clinic. At the same time, women's narratives revealed an unexpected benefit of the insurance program: membership in the insurance program confers women access to a larger citizenship. This insight demonstrates the potential that insurance has in reviving an essential component of the social contract between the Haitian state and its citizens. The field of health insurance emerges from our study as a potent arena for the Haitian state to reclaim its role in providing for the health of its people.

10. Recommendations

Drawing of the main findings that emerged from the study, we formulate the following recommendations. These recommendations take into account the design of a health insurance for poor people, the role of the state and international partners in the effort to provide equitable access to health care in Haiti.

Rethinking user fees

The women's experiences with user fees challenge all the presumed benefits advanced by user fees advocates. Based on the suffering voiced by the study participants we argue that user fees contribute to the structural violence that poor people face. Therefore we recommend the elimination of user fees for impoverished people seeking care. More than a recommendation, it is a moral claim. As Keshavjee claims: "we cannot ask starving people to pay for medicines"(Keshavjee, 2014).

Appropriate health insurance design

Looking at the women experiences with the IOM insurance, we can conclude that short-term insurance with limited coverage of services cannot properly address the needs of poor people. Therefore we recommend that a health insurance should offer the following:

- A meaningful package of medical services
- Long-term provision of these services
- Geographically decentralized coverage.

“Putting people first” in global health interventions

Through our study, we also saw that the prevailing logic of humanitarian work, which focuses on donors’ agenda instead of beneficiaries’ real needs, is one of the causes of the flaws of the IOM insurance program. There is therefore a call for the global health community to change the logic and “put people first.” Those designing humanitarian interventions should consider both the perspectives of the people they serve and also the local context. This perspective change would allow the global health community to design projects that address the critical aspects of people’ problems instead of providing acute responses that are inappropriate to provide real solutions to the poor. The takeaway lessons for global health provided by this study are that:

- People’s voices matter
- Context matters
- Acute responses cannot address the chronic issue of poverty.

Reviving the social contract between the state and the citizens

The field of health insurance emerges from our study as a potent arena for the state to reclaim its role in providing for the wellbeing of its people. In regards to the current financial challenges that the Haitian state faces, it is unlikely that Haiti will be able to provide national health insurance coverage without outside assistance. However, the state can take more concrete actions to advance this goal.

- Increase the national health budget

This would provide more resources to improve the quality and the access to care, especially for poor people in the public sector. An increase in the national health budget could also send to the international partners a signal of the active implication of the state to improve to address the health challenges. Finally, we expect this kind of action to rebalance the power between the state and the international community.

- Extend public insurance to the disadvantaged

Building the health system as way to achieve equity in access to care

In light of the IOM insurance, we second Farmer, Sen and Drèze's argument that a strong public system is essential to reach equity in access (Dreze & Sen, 2013; Farmer, 2015). There is therefore a call for both local and international stakeholders to concentrate efforts to build Haiti's health system. Specific recommendations would be:

- Increasing donors' direct funding to the ministry of health.
- Investing international funding in existing public facilities
- Funding the public health insurance in view of expanding access for poor people

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